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EDITORIAL

European Network for Patient Safety and Quality of Care: PaSQ

La red de la Unión Europea para la Seguridad del Paciente y la Calidad Asistencial: PasQ

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Since 2005, the European Union (EU) has been paying a special attention to the topic of patient safety: first by creating a working group on patient safety within the high level group on health services and medical care; then through the public health program. To advance knowledge on patient safety and enhance collaboration in this field, two projects were co-financed: SIMPaTIE[1] and EUNetPAS.[2]

A major step was made when the Council of the EU adopted in June 2009, a recommendation on patient safety[3] advising Member States on actions to be taken to improve patient safety in the EU. This was followed by the launch in April 2012 of the Joint Action ''The European Union Network for Patient Safety and Quality of Care'' (PaSQ) contributing to the implementation of the Council recommendation. The aim of the joint action, gathering most Member States and the main European stakeholders was to exchange good practices and experiences in the field of quality of care, including patient safety and patient involvement.[4]

To achieve this objective, one of the core features of PaSQ has been the selection, implementation and monitoring of safe clinical practices (SCP) in healthcare organizations from different EU countries. This work has been performed within one of the seven work packages composing the joint action, namely work package 5 on ''Patient Safety Initiatives Implementation'', led by the German Agency for Quality in Medicine[5] with HOPE as the co-leader.

A total of 220 healthcare organizations from 18 European countries took part in the implementation of selected SCP contributing to the improvement of patient safety and quality of care in Europe. Healthcare organizations involved represented not only hospitals but also primary care centers and nursing homes. 81 out of the 220 healthcare organizations were from Spain.[6] In total, 106 of these were involved in medication reconciliation, 86 in the WHO surgical safety checklist, 81 in multimodal intervention to increase hand hygiene compliance and 35 in the pediatric early warning scores (PEWS).

Those four practices were identified through a literature review and were selected based on five criteria: demonstrated effectiveness in clinical trials; transferability to different healthcare systems and healthcare contexts or clinical specialties; feasibility of implementation within PaSQ; existing available implementation tools; enablement of patient involvement.

The implementation process monitored and assessed within work package 5 lasted one year. Progress has been monitored and assessed through the administration of a baseline questionnaire in September 2013 and an end line questionnaire in September 2014. The questionnaires were

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completed online by the healthcare organizations coordinators for each of the SCPs implemented in their own institution.

Findings from the baseline questionnaire show that surgical safety checklists and hand hygiene practices were already largely in use in the participating healthcare organizations. 79% of healthcare organizations coordinators reported that surgical safety checklists were in use in their institution and more than 80% were applying hand hygiene. Nevertheless, PaSQ provided the chance for healthcare organizations to deepen the implementation, establish evaluation aspects and ways of continuous improvement of these safe clinical practices.

When comparing situations at baseline and end line, the level of use of these practices increased during the one-year timeframe by 21% for surgical safety checklist and by 16% for hand hygiene. There was also a progress in the implementation of the practices' process steps and components as these were declared to have been fully implemented by a higher number of healthcare organizations in the end line questionnaire.

As regard medicine reconciliation and PEWS practices, represented an opportunity for healthcare organizations to get started. These were indeed the SCPs for which major developments have been observed. In the baseline questionnaire, the percentage of use declared by healthcare organizations coordinators for medication reconciliation and PEWS was respectively of 30% and 7% only, whereas in the end line questionnaire this rose to 78% and 67%. This means an increase of 48% for medication reconciliation and 60% for PEWS in one-year time.

When asked about the impact of the practice implementation, most of healthcare organizations coordinators strongly agreed that implementation of surgical safety checklist; hand hygiene and medication reconciliation had a positive impact on organizational culture, process quality and patient outcomes. For the PEWS, the majority of respondents agreed that the implementation had a positive impact on organizational culture and process quality whereas, when asked about the impact on patient outcomes, they stated this was not applicable at that time.

As regard PaSQ benefits, more than half of the healthcare organizations coordinators (between 53% and 79%) answered in the baseline questionnaire that through their participation they hoped to exchange experiences with other healthcare organizations nationally and internationally, thus assisting them in the practices implementation. This was achieved in between 29% and 73% of the healthcare organizations, according to the feedback received in the end line questionnaire.

Regarding Spanish participation in WP5, the Ministry of Health, Social Services and Equality (MSSSI) invited all of the 17 Health Regions to participate in the implementation of the SCPs. The selected centers, in each region, committed to implement and evaluate the practices they had chosen and to appoint a coordinator of the center to take care of implementation and the evaluation process.

Three levels of coordination – national, regional and local – were established to ensure a successful implementation of the practices, through four working groups (one for each practice). The MSSSI coordinated the four groups at the national level, in collaboration with the coordinators who were appointed at the regional level, to agree on planning aspects for implementation, follow up and the evaluation of the SCPs. The regional coordinators led the implementation at the regional level, being responsible for informing and selecting the participating centers, establishing a commitment with the managers about the organization, data collection and feedback. They also provided the resources for the implementation, when needed. At the local level, at least one coordinator was appointed to be responsible for the clinician's involvement, as well as for the practice implementation, data collection and monitoring. Analysis of barriers and proposals for improvement were performed at the three levels.

Coordination was done through quarterly teleconferences with each group, in order to clear up any doubts during the follow up, discuss the indicators selected, share experiences and find solutions to general problems encountered. This was also an opportunity to know the opinions of the coordinators and professionals about the pros and cons on PaSQ participation. In addition, a virtual space was created (e-Room), which facilitated the continuous exchange of information among all participants.

To assess the impact of the implementation a set of structure, process and output and outcome indicators for each practice were agreed with the regions to provide additional information to the WP5 questionnaires.

A total of twelve out of the seventeen Spanish Health Regions agreed to implement one or more SCPs; but only two of them have been implemented all four of them. The participating Health Regions provided a total of 117 healthcare centers, 64% of them were hospitals, 32% primary care centers and 4% others (nursing homes and mental health centers).

The most frequent practice implemented was medication reconciliation (71.1%), followed by safe surgical checklist (38.3%), hand hygiene (34.2%) and PEWS (16.4%)

Seven regions implemented the surgical checklist in a total of 31 hospitals and one primary care district. The hand hygiene multimodal strategy was implemented in 36 centers in 5 regions. The implementation of these both practices was cofunded by the MSSSI, from 2006 to 2011, in the framework of the National Patient Safety Strategy,[7] which could explains why they were both partially implemented in 90% of the participating centers. Also, in the case of hand hygiene, a national program has been running since 2008 in collaboration with all of the regions, which means that most of the Spanish hospitals are implementing this practice, at least partially.[8] PaSQ participation led to a change in the approach to implementation and evaluation of both practices. Thus, in the case of hand hygiene there was an opportunity to include indicators to assess adherence to the ''5 moments'' in all of the participating organizations. In the case of the surgical checklist, there was an opportunity to begin planning a national program on safe surgery.

Eight regions participated, with 74 centers, in the implementation of medication reconciliation and 12 hospitals from 3 regions in the PEWS. In the baseline questionnaire, the percentage of use declared by healthcare organization coordinators for medication reconciliation and PEWS was respectively 30% and 0%, whereas in the end line questionnaire this rose to 84% and 100%.

When asked about barriers and facilitators, most health center coordinators agreed that resistance to change was the main barrier, followed by lack of culture (in the case of surgical checklist and hand hygiene) lack of resources (in the case of medication reconciliation) or professional involvement (in the case of PEWS). Leaders' support was the main facilitator for the four practices, followed by enough resources (in the case of safe surgical checklist and hand hygiene) and good communication among the team (in the case of medication reconciliation and PEWS).

The national network created since 2006 around the patient safety strategy, the deployment of the strategy at the regional level and the high motivation of professionals to participate in European projects could explain the high participation of Spanish health organizations.

Spanish participation in PaSQ has been an opportunity to boost the patient safety strategy at the national and regional levels as well as to facilitate front line professionals, leadership and commitment. However, the networking with the front line professionals has to be improved in order to get them more involved in real change to improve patient safety.

In summary, the results of the one-year implementation monitored and assessed within the work package 5 are overall encouraging as they illustrate a positive development in the implementation of all four selected SCPs around the European Union.[9]

From a policy perspective, findings from the SCPs implementation held within work package 5 highlight the importance to continue collaboration at EU level in the areas of patient safety and quality of care. This collaboration is even more important in light of Directive 2011/24/EU on the application of patients' rights in cross-border healthcare. Among its aims, the Directive indeed intends to facilitate patients' mobility in the EU and access to safe and high quality healthcare services so to help patients making informed choices when crossing borders to receive healthcare.

The Council of the EU in its recent conclusions invited the Member States and the Commission to finalize, by December 2016 a framework for a sustainable EU collaboration on patient safety and quality of care, taking into account the results of PaSQ.[10]

We do hope a way will be found to continue the SCP implementation experience in a sustainable manner in the European Union.

Conflict of interests

The authors have no conflict of interests to declare.

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