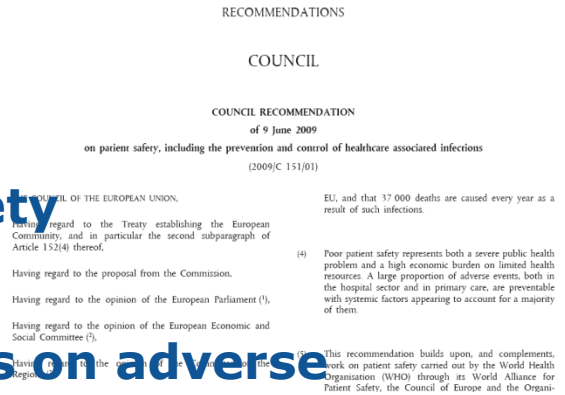
Patient safety and healthcare associated infections

Report from the Commission to the Council

Council Recommendation 2009/C 151/01



RECOMMENDATIONS

COUNCIL

COUNCIL RECOMMENDATION

of 9 June 2009

on patient safety, including the prevention and control of healthcare associated infections

(2009/C 151/01)

THE COUNCIL OF THE EUROPEAN UNION,

Having regard to the Treaty establishing the European Community, and in particular the second subparagraph of Article 152(4) thereof,

Having regard to the proposal from the Commission,

Having regard to the opinion of the European Parliament (1),

Having regard to the opinion of the European Economic and Social Committee (2),

EU, and that 37 000 deaths are caused every year as a result of such infections.

(4) Poor patient safety represents both a severe public health problem and a high economic burden on limited health resources. A large proportion of adverse events, both in the hospital sector and in primary care, are preventable with systemic factors appearing to account for a majority of them.

(5) This recommendation builds upon, and complements, work on patient safety carried out by the World Health Organisation (WHO) through its World Alliance for Patient Safety, the Council of Europe and the Organi-

Actions for Member States:

- **Develop national policies on patient safety**
- **Inform and empower patients**
- **Establish reporting and learning systems on adverse events**
- **Promote education and training for health workers**
- **Adopt and implement a strategy to prevent and control healthcare associated infections**

Actions for EU collaboration:

- **Classify and measure patient safety**
- **Share knowledge and experience**
- **Develop and promote research**

Council Recommendation 2009/C 151/01

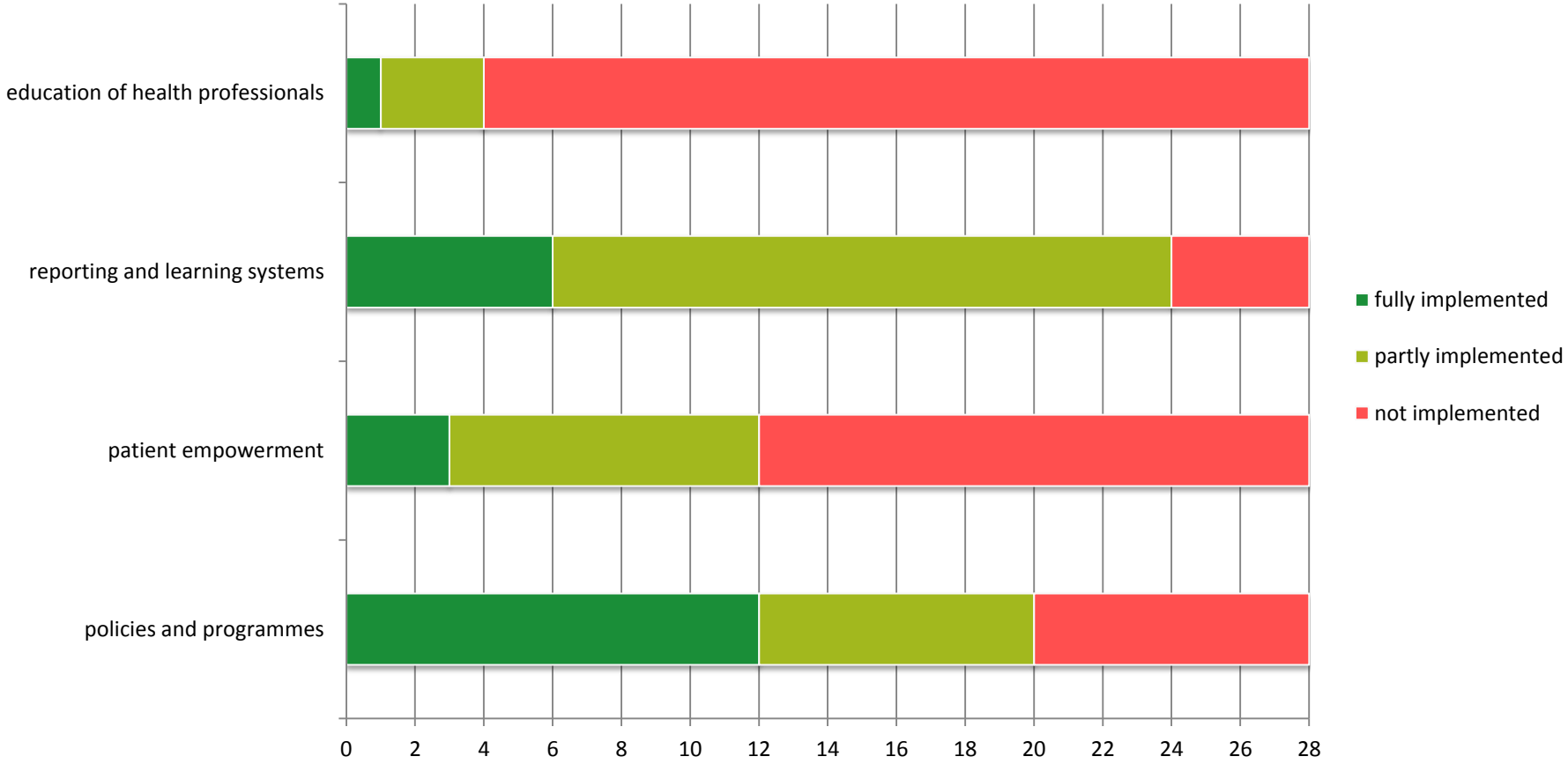
The Council invites the Commission to produce an implementation report to the Council

- **assessing impact of this Recommendation, on the basis of the information provided by Member States,**
- **to consider the extent to which the proposed measures are working effectively, and**
- **to consider the need for further action.**

The Report is based on:

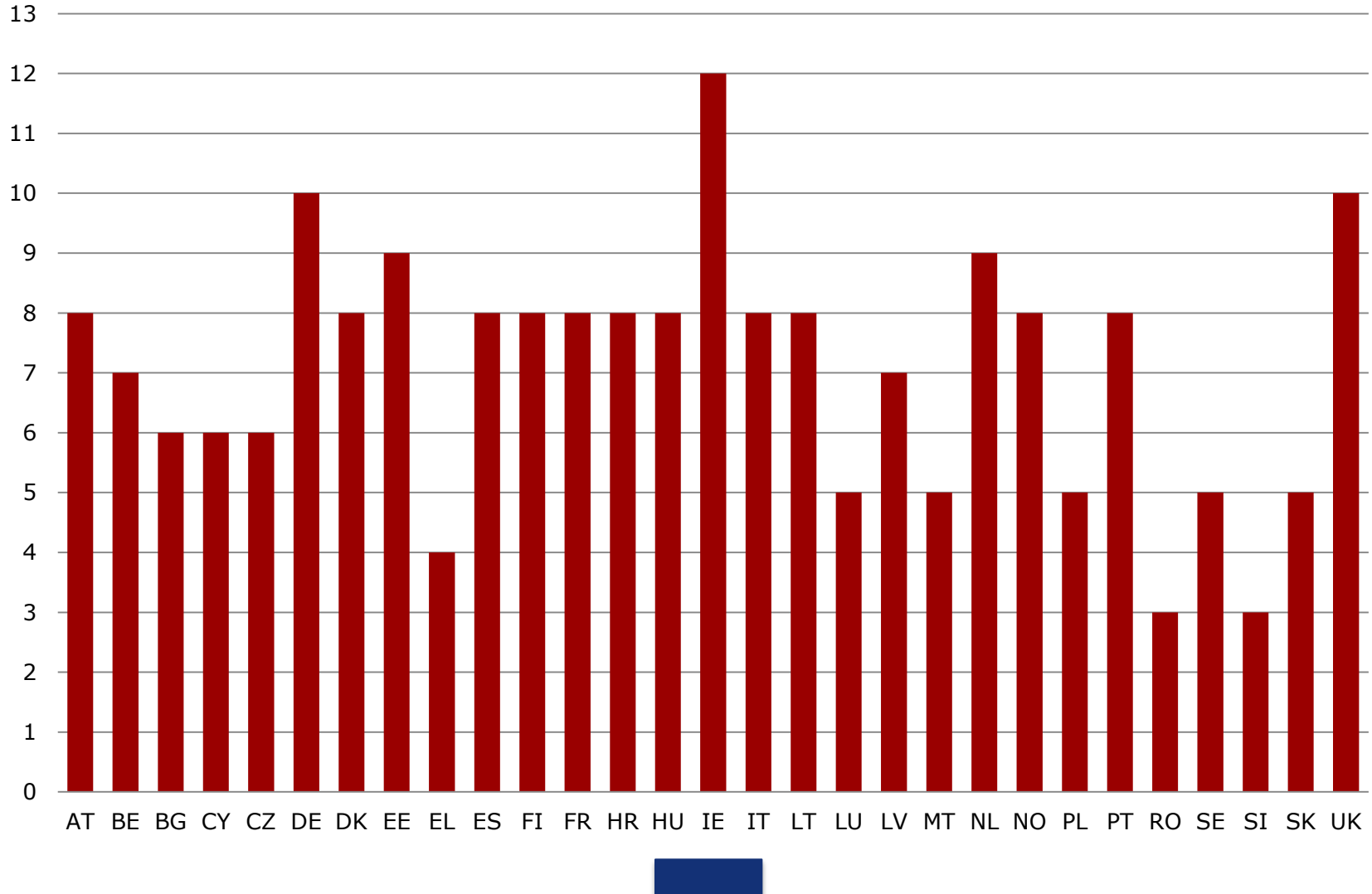
- *Replies from Member States to a standardized questionnaire*
- *Replies to a public consultation (181 replies received mainly from health professionals, hospitals and patients organisations)*
- *Eurobarometer survey on patient safety and quality of care carried out in 28 Member States*

Implementation by actions at MS level



MS questionnaire

Implementation by countries



Implementation at EU level

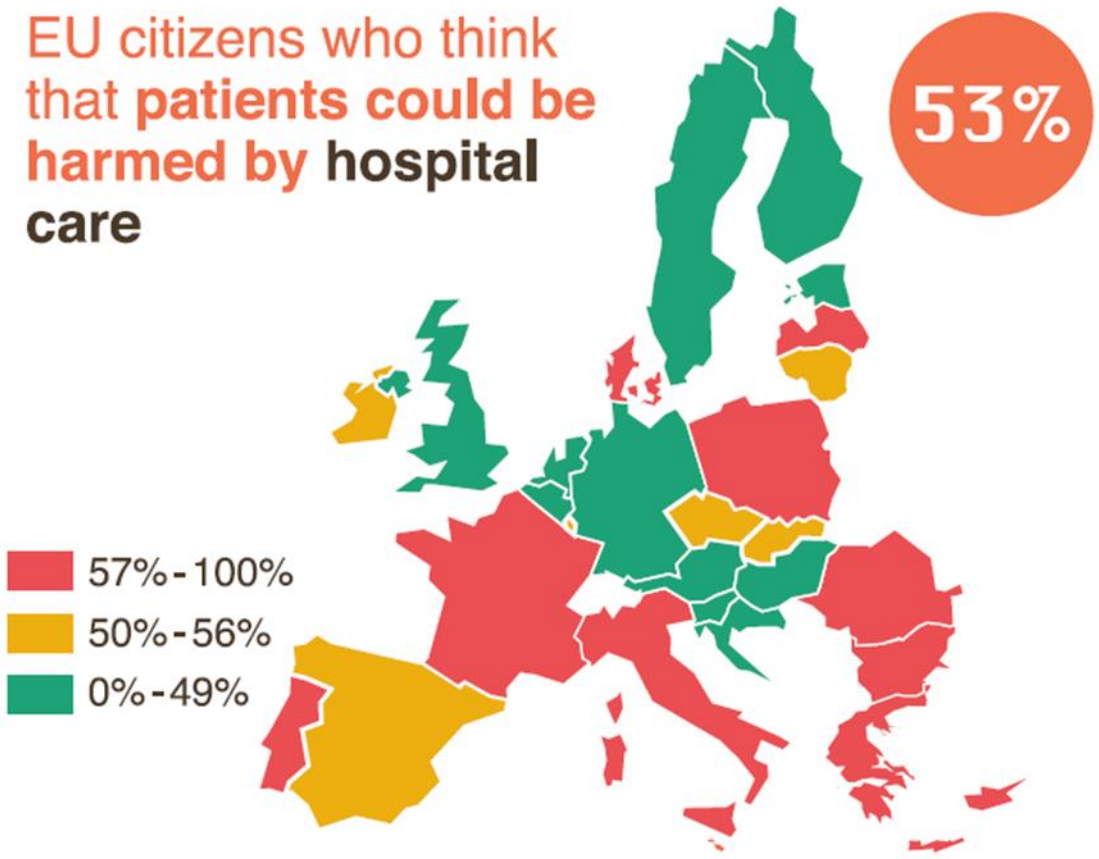
- **Classify and measure patient safety**
  - Co-financing of the Health Care Quality Indicators Project led by OECD
  - Agreement with WHO on delivering EU patient safety taxonomy
- **Share knowledge and experience**
  - EU expert group on patient safety and quality of care
  - Co-financing of the EU network on patient safety and quality of care
- **Develop and promote research**
  - Co-financing of projects within the Health Programme and research programme FP7

Eurobarometer: citizens' perception

European Commission

Patients think they can be harmed

EU citizens who think that **patients could be harmed by hospital care**



No change since 2009

Eurobarometer: patients' experience

European Commission

Education and training of healthcare workers

Reporting incidents and learning systems

Patients...**

...experiencing an adverse event...

27%

...reporting it...

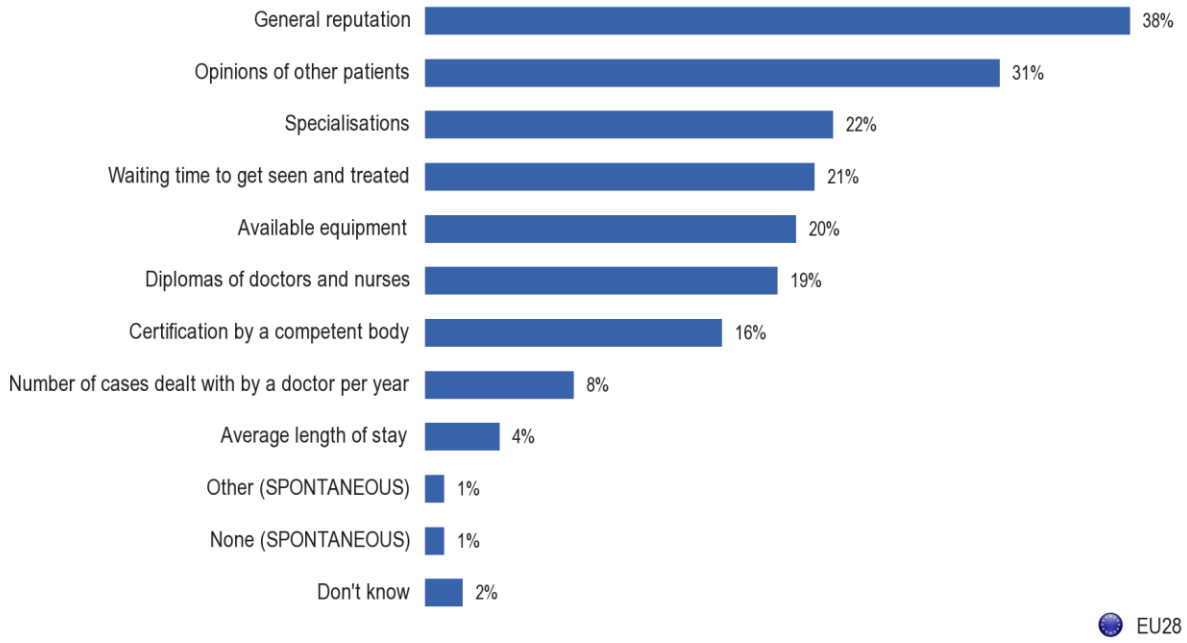
46%

...to what result

European Commission

Europeans are most likely to take general reputation (38%) and the opinions of other patients (31%) into account when assessing the quality of a hospital

QC5. What information would you find most useful to assess the quality of a hospital?



Impact of the Recommendation

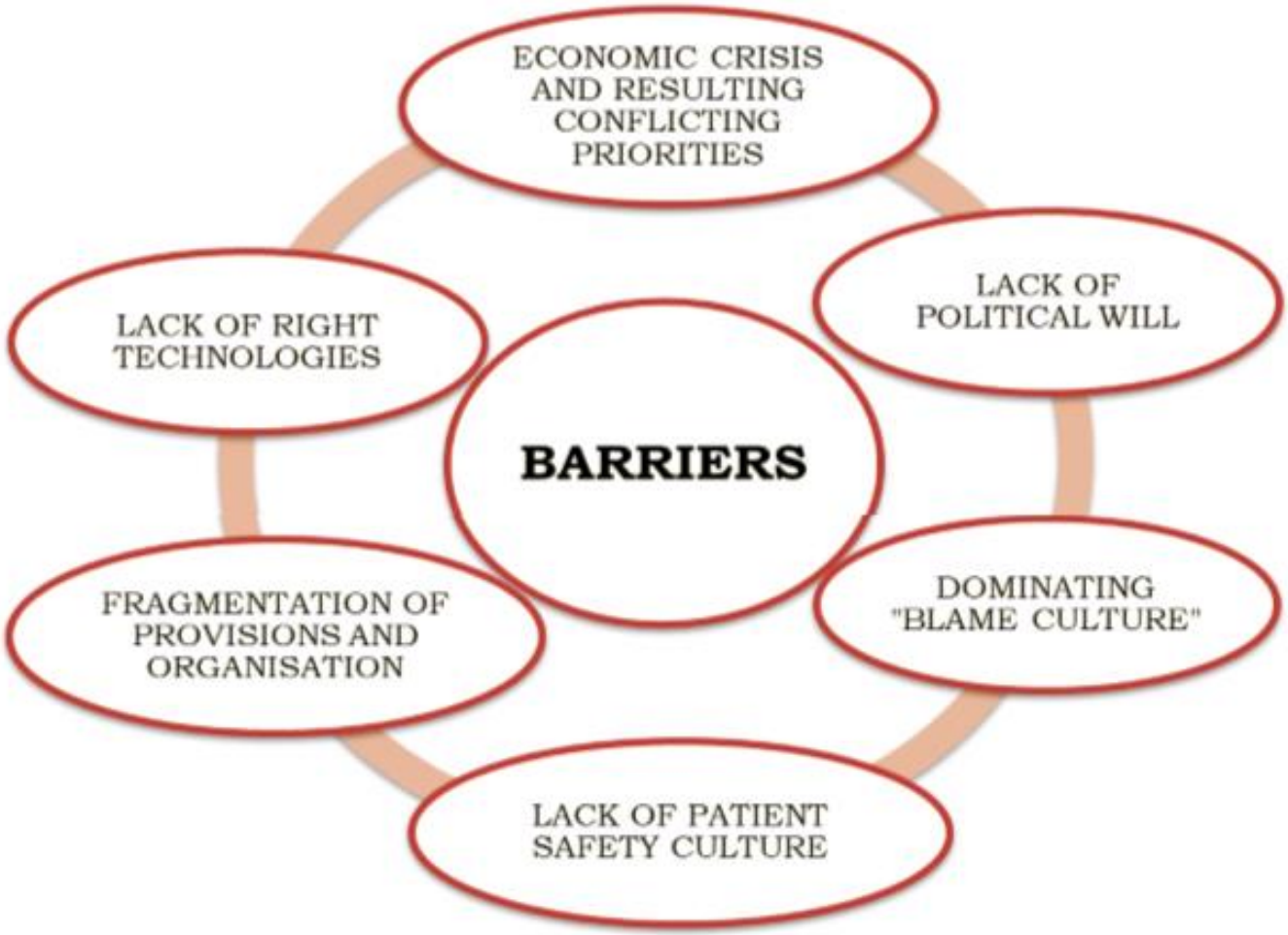
According to Member States:

- **Increased awareness at political level and trigerred concrete actions, e.g. development of patient safety strategies and programmes, inclusion of patient safety in health legislation**
- **Increased awareness at healthcare setting level**

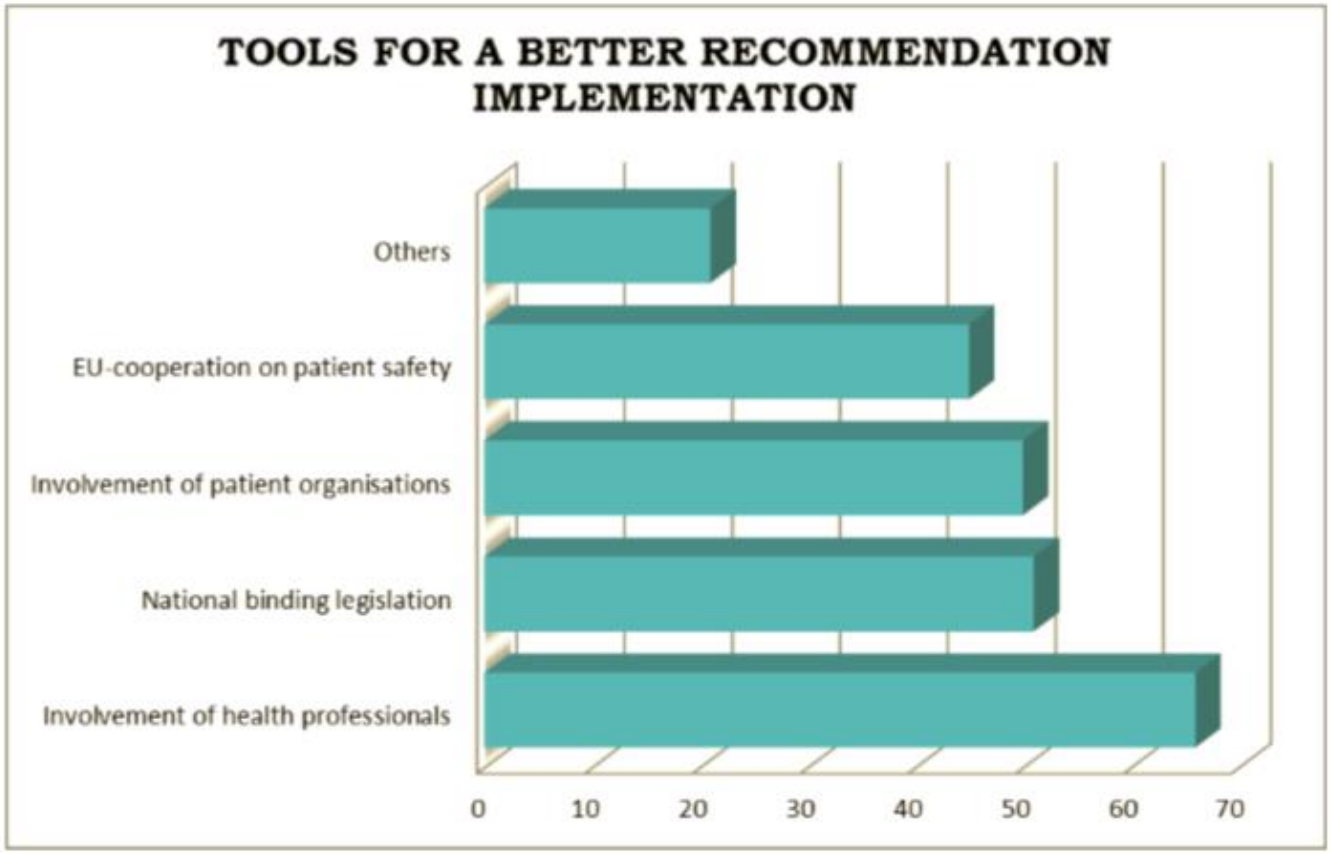
According to stakeholders:

- **Contributed to improving patient safety**
- **Raised awareness at political level**

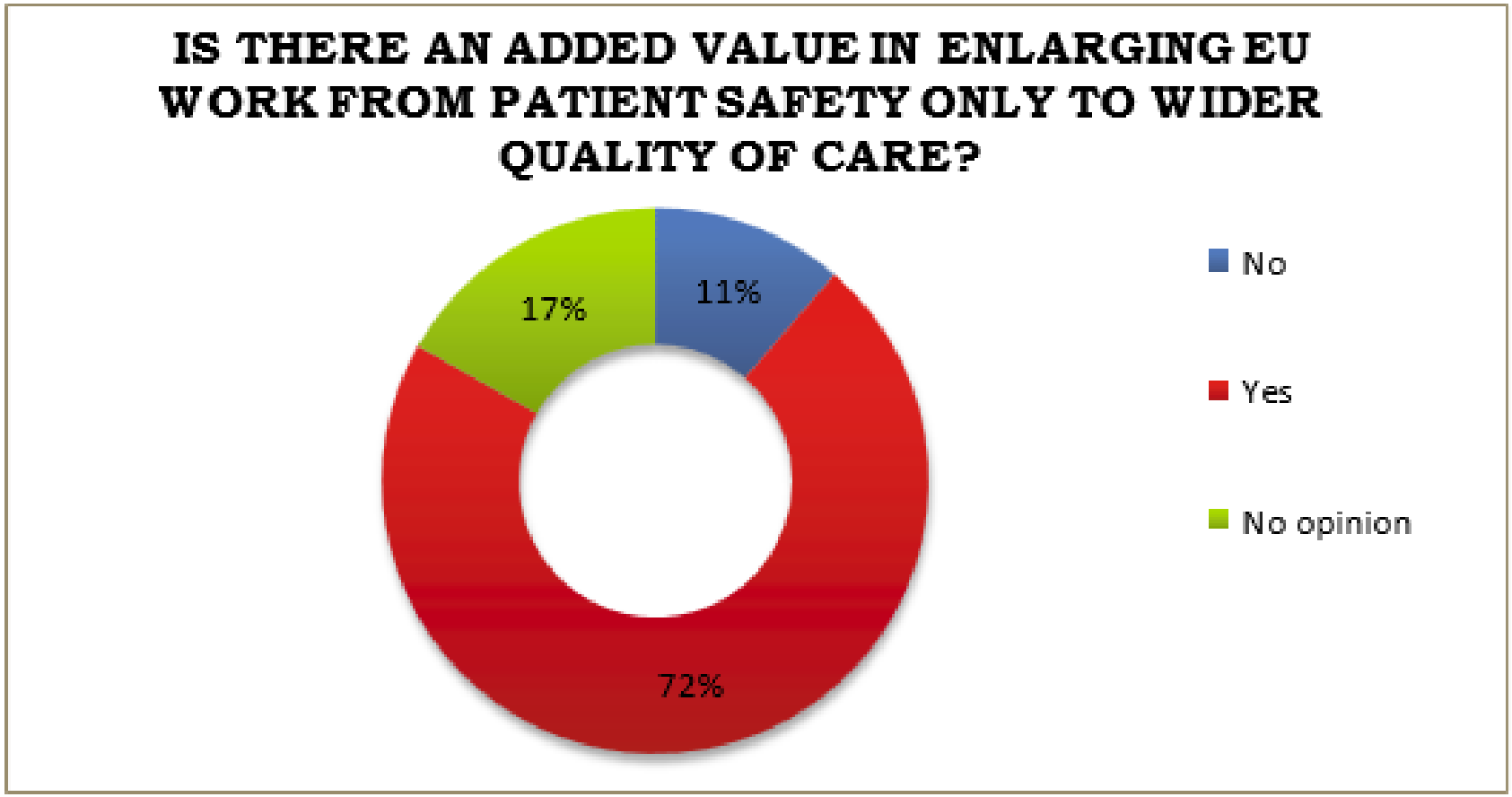
Public consultation



Public consultation



Public consultation



Progress made, more needed

- Awareness raised at political level, patient safety embeded in national policies and legislation
- Good climate to improving patient safety in the EU
- Patients better aware of possibilities of reporting adverse events

BUT

- Lesser impact at healthcare setting level
- No systematic follow-up of reported adverse events
- Citizens still not confident about quality and safety of healthcare

Suggested follow-up measures

1. *A common definition of quality of care and support for common terminology, common indicators and research on patient safety;*
2. *EU collaboration on patient safety and quality of care;*
3. *Guidelines on how to provide information to patients on quality of care;*
4. *EU guideline on how to build patient safety and quality of care standards;*
5. *Reflection on the issue of redress as provided for in Directive 2011/24/EU);*
6. *Encouraging training for patients, families and informal carers;*
7. *Encouraging reporting as a tool to spread a patient safety culture.*