

Speed-poster session 2

Friday 30th September



Speed-poster session rules

One slide – one minute – per poster



Presenters

1. A new special competence in health care quality and patient safety for Finnish physicians and dentists.
» **Dr. Maiju Welling**
2. Cultural diversity in healthcare teams: an integrative review.
» **Prof. Timur Uman, Dr. Manuela Schmidt**
3. A narrative synthesis of patient safety culture.
» **Mrs. Anja Vibe**
4. Developing quality measures for rehabilitation in the primary health care setting for persons with chronic disease: a best practice conceptual framework using consensus methods.
» **Mrs. Hanne Sondergaard**
5. Trends in dispensing errors reported in Finnish community pharmacies in 2015–2020.
» **Ms. Emilia Mäkinen**
6. Do we have a terminological problem in patient safety? – A comparative graph-based analysis of CIRS-Classifications in Germany and Swiss.
» **Prof. Thomas Schrader**
7. Evaluating a system-wide, safety investigation in healthcare course in Norway: a qualitative study
»
8. The effect of full-time culture on quality and patient safety in primary healthcare service - a literature review.
» **Mrs. Malin Mageroy**



A new special competence in health care quality and patient safety for Finnish physicians and dentists



Starting point in 2019:
We need more
physicians in quality and
patient safety work!



2021: Approval by the
FMA and also the Finnish
Dental Association



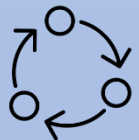
2021: Organization of the
Competence Committee
and planning of the
application process

2019-2020: A lot of discussions,
consultations and modifications
of the proposal

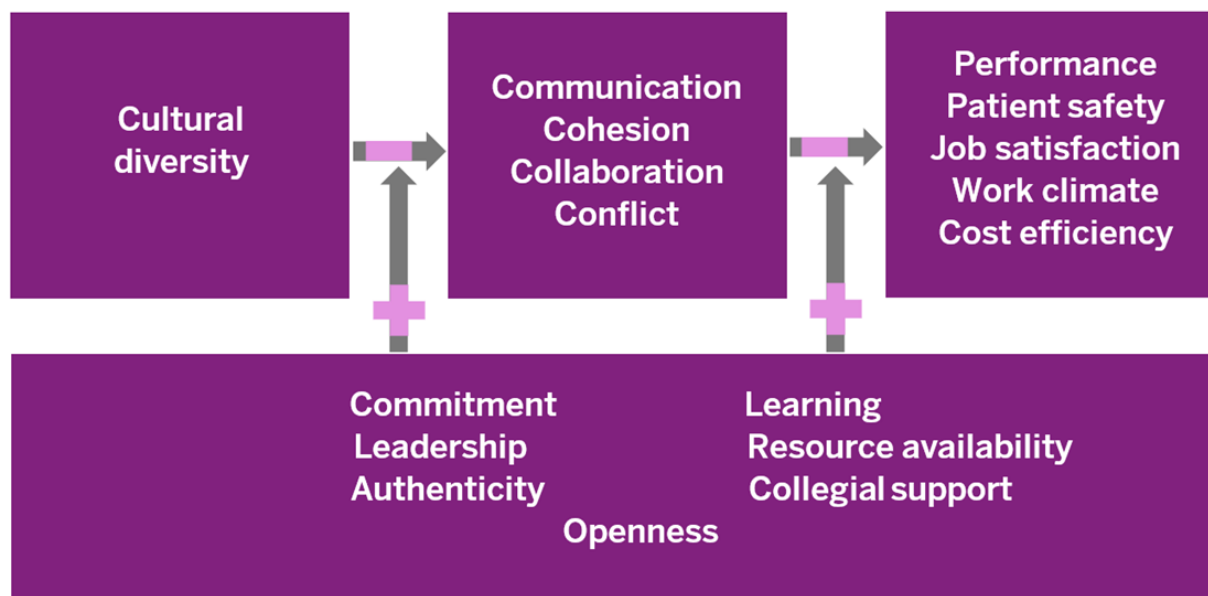


Proposal for a new
special competence to the
Finnish Medical
Association (FMA)

2022: First application
rounds and so far 39
issued special
competences



CULTURAL DIVERSITY IN HEALTHCARE TEAMS - AN INTEGRATIVE REVIEW AND RESEARCH AGENDA

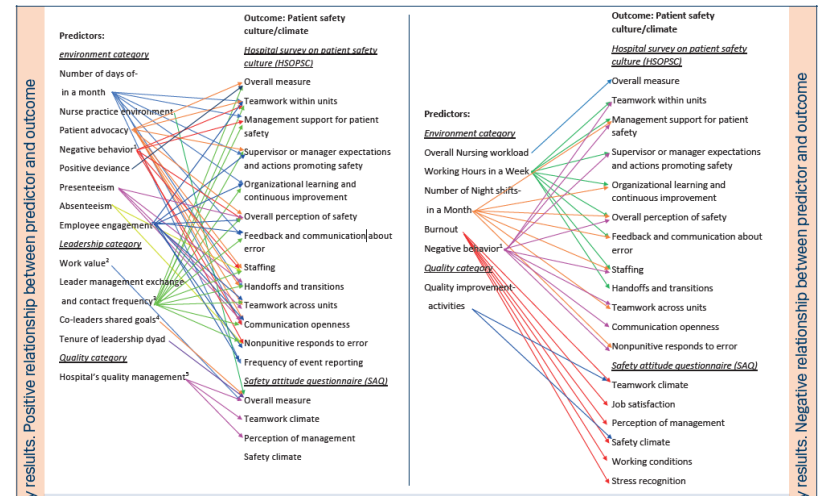


Manuela Schmidt¹, Norbert Steigenberger², Magnus Berndtson³, Timur Uman¹

¹ Jönköping University, ² Umeå University, ³ Qulturum, Region Jönköping County, Sweden



Categories	Reporting of adverse events	Environment	Quality	Learning	Leadership	Communication
Themes derived from studies	<p>The reality of reporting incidents</p> <p>Encouraging individual and org. learning from incidents reporting</p> <p>Underreporting of events, cumbersome documentation systems</p>	<p>Defining safety culture</p> <p>Influences of team culture</p> <p>Differences in environmental impact</p> <p>To secure that enough staff were present during each shift and</p> <p>Unsafe staffing</p> <p>Long work hours</p>	<p>Infection control practice failures, compliance issues with policies</p> <p>Balancing adherence to and questioning of standardized operative procedures</p> <p>Commitment to best practice and patient care</p> <p>Units use the tools shared in hospitals risk management policy</p>	<p>Inadequate training, Managers emphasized expertise and continuous development of staff members.</p> <p>Proactive tools is still not daily practice and their embedment and acceptance by nurses physicians and managers is limited</p>	<p>The level of culture is stated to be bureaucratic.</p> <p>Being present as a leader and a good example</p>	<p>Instances of communication breakdown</p>



DEVELOPING QUALITY MEASURES FOR REHABILITATION IN THE PRIMARY HEALTH CARE SETTING FOR PERSONS WITH CHRONIC DISEASE: A BEST-PRACTICE CONCEPTUAL FRAMEWORK USING CONSENSUS METHODS

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INTRODUCTION

The Local Government Denmark and the municipalities are working to identify the best way to establish a nationwide quality assessment of rehabilitation for persons with chronic disease. The increasing disease burden of chronic disease make systematic assessment of the delivery of care key to facilitate improvements in patient outcome.

OBJECTIVES

To develop nationally applicable quality measures of rehabilitation in the primary health care setting for persons with chronic disease.

METHODS

The project was designed in accordance with a best-practice conceptual framework for developing quality measures, and was led by methodologists (1). The project ran from January 2020 to September 2021. An expert panel was established in order to yield consensus recommendations on quality measures using the methods illustrated in Figure 1. The expert panel included 11 representatives counting a patient representative, health care professionals, a methodologist, and researchers within the field. The recommendations from the expert panel were finally approved by the panel and by a steering group including the Danish Ministry of Health, the Danish Regions, and the Local Government Denmark.

RESULTS

Consensus was demonstrated on the quality measures assessing whether the patients are offered participation in, and adhere to, the following components:

- Patient education
- Smoking cessation
- Physical exercise training
- Nutritional efforts
- Preventive consultation on alcohol consumption

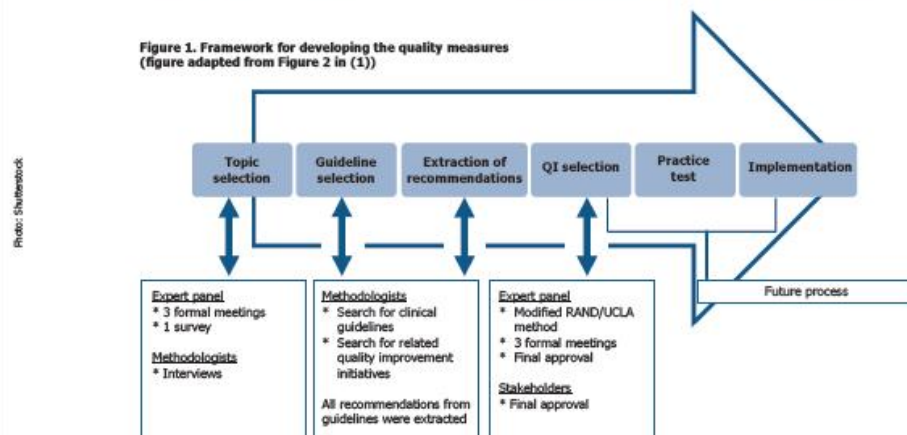
Furthermore, consensus was reached on the quality measures assessing whether the patients participate in a closing rehabilitation meeting, and whether they are offered follow-up.

CONCLUSION

Consensus was demonstrated on quality measures constituting a framework for assessing the quality of rehabilitation in the primary health setting in Denmark for persons with chronic disease. When developing quality measures, it seems key that a close link exists between the rehabilitation practices in the primary health care settings, patient relevance, a strong evidence base through existing national clinical guidelines, and strategic professional and political partnerships. Next step focuses on field testing of the quality measures to refine measure criteria and assess implementation.

1. Kötter T, Block E, Scherer M. Methods for the guideline-based development of quality indicators – a systematic review. *Implement Sci* 2012;7:21.

Figure 1. Framework for developing the quality measures
(figure adapted from Figure 2 in (1))



TRENDS IN DISPENSING ERRORS REPORTED IN FINNISH COMMUNITY PHARMACIES IN 2015–2020

Mäkinen E, Airaksinen M, Holmström A-R, Schoultz A



INTRODUCTION

In Finland, a national register for dispensing errors has been maintained by the Association of Finnish Pharmacies since 2012. After establishing the system, there have been several safety advancements made to the dispensing processes.

OBJECTIVES

To analyze trends in dispensing errors reported in Finnish community pharmacies during the years 2015–2020.

METHODS

This was a retrospective registry-based study, in which errors reported to the dispensing error register for the period from January 2015 to December 2020 (n=19 550) were analyzed.

- Descriptive statistics (frequencies and percentages)
- Poisson regression
- Binary logistic regression

MAIN RESULTS

- The annual number of dispensing error reports had decreased significantly (n=3 913 in 2015; n=2 117 in 2020)
- The differences were greatest between the years 2018 and 2020
- The most common error types were incorrect strength (50%, n=9 849) and incorrect quantity or package size (13%, n=2 512)

CONCLUSION

A decreasing trend was identified in the dispensing errors reported to the Association of Finnish Pharmacies dispensing error registry. A decreasing trend may be related to recent changes in dispensing process toward automation and digitalization in the Finnish community pharmacies.

Do we have a terminological problem in patient safety? A comparative graph-based analysis of CIRS-Classifications in Germany and Swiss

Schrader
Tetzlaff
Paula



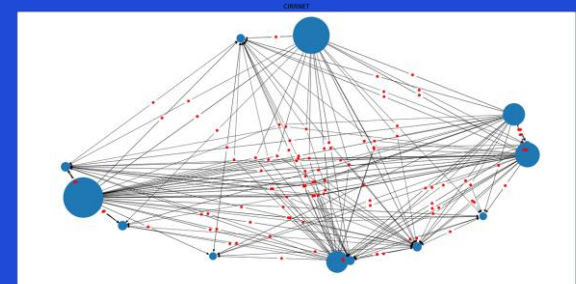
Classification behavior

A part of CIRS analysis is the classification of cases according to the WHO International Classification of Patient Safety (ICPS) from 2009.



A Graph

Graphs consist of nodes and edges. Graphs can be used to investigate and represent relationships between different topics.



Various pattern

There are significant differences in classification behavior between the reporting systems relegated to links between report and classification items.

Evaluating a system-wide, safety investigation in healthcare course in Norway: a qualitative study

Cecilie Haraldseid-Driftland, Carl Macrae , Veslemøy Guise , Lene Schibevaag, Janne Gro Alsvik, Adriana Rosenberg & Siri Wiig

Background:

- National, system-wide safety investigation represents a new approach to safety improvement in healthcare.
- In 2019 a new master's level course in Safety Investigation in Healthcare was established to support the training and development of a new team of investigators from an independent investigatory body.

Aim:

- The aim of this study was to qualitatively evaluate the course

Results:

- In need of a common conceptual foundation for a multidisciplinary group
- Course participation contributed to create reflexive spaces
- Generated new knowledge about the need for a broad range of investigatory tools and approaches.
- Contrasted with the initial aspiration among the participants to have a recipe for how to conduct safety investigations.

Qualitative approach



Individual and focus group interviews

Participants



Managers and safety investigators

Malin Rosell Magerøy, malin.r.mageroy@uis.no

The effect of full-time culture on quality and patient safety in primary healthcare service- a literature review

- Systematic literature search
 - Safety outcomes for patients and staff
- 4 main themes
 - Length of shift
 - Fatigue/burnout
 - Autonomy/empowerment
 - System/structure



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