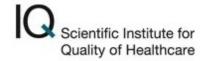
Developing the University of Tartu to a well-networked PATient SAFEty research center in Estonia (PATSAFE)





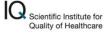


The PATSAFE project: Research and educational perspectives

Dr. Carola Orrego, Anne van Tuijl, MSc







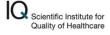
Introductions

MENTIMETER LINK

- During this presentation we invite you several times for interaction through Mentimeter.
- Please go to www.menti.com and use the code 46903151.
- To start with: a 1st question about the participants characteristics in this session:
 - In which position do you (mainly) work?
 - Answering options are academic staff, early-stage researcher, clinician, nurse, policy officer or other







Background

- Patient safety represents a global public health problem which affects countries at all levels of development
- Nonetheless, there is a scarcity of research evidence on how to tackle this global health priority.
- According to the WHO, more knowledge is essential for understanding the
 extent and causes of patient harm, and for developing solutions that can be
 used in different contexts.
- A key strategy is developing competencies to promote research including not only the magnitude of the problem but also how translate the evidence into the clinical practice





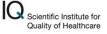


Background, continued

- In this context and based on the previous experiences and published knowledge, we developed the PATSAFE training program
- The program was developed based on training needs analysis and addressed to academic staff, early stage researchers, clinicians and managers interested in patient safety
- Combination between patient safety topics and research skills







Objectives

Aim of PATSAFE

Improve and strengthen research excellence of the ICM-UT in the field of patient safety research among the early-stage researchers (ESRs) and staff with a special focus on the improvement of knowledge and skills in methods, technics and experience for patient safety research.

Aim of this presentation

To describe the education and research activities developed in PATSAFE and sharing main outputs, lessons learnt and further opportunities for sustainability.







The PATSAFE training program

MODULE 1

- The science of patient safety and burden of unsafe care
- 2. Methods of analysis of adverse events and improvement of patient safety (I)
- Methods of analysis of adverse events and improvement of patient safety (II)
- Implementation science and patient safety improvement

Fundamentals in patient safety culture and patient involvement in patient safety research

Building soft skills for

patient safety

research

MODULE 3

- 1. Research proposal
- 2. Research ethics
- Intellectual property rights and commercialization in research
- 4. Human resources and change management in clinical settings
- 5. An introduction to qualitative research

MODULE 2

- 1. Patient safety culture
- Patient involvement in patient safety and patient safety research
- Validation techniques of measurement tools to study patient safety culture in healthcare settings in Estonia
- Literature review techniques directed at identifying interventions to improve patient safety culture

Please go to:

www.menti.com; code 46903151 and answer this question:

Which area do you think you need more training in?







Module 1: Fundamentals of patient safety

The science of patient safety and the burden of unsafe care

Methods of analysis of adverse events and improvement of patient safety (I)

Methods of analysis of adverse events and improvement of patient safety (II)

Implementation science and patient safety improvement

Patient safety science

Epidemiology and nature of adverse events Basic concepts and taxonomy of adverse events

Root cause analysis and sentinel adverse events

Reporting systems

Trigger tools (including global, surgery, ICU, medication)

Patient safety indicators

Disclosure of adverse events to patients

Supporting second and third victims

High risk processes and process reliability

Proactive methods of risk and hazard analysis

Healthcare Failure Mode and Effects Analysis (HFMEA)

Complementary methodologies emerging from the field of safety-critical engineering Creating environment for patient safety (high reliability organisations)

> Evidence-based patient safety practices Implementation science in patient safety

Study designs used in implementation projects to improve patient safety

Research gaps and how to publish initiatives on patient safety in peer-review journals



High impact adverse events

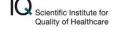












Fundamentals of patient safety

Module 2: Patient safety culture and patient safety involvement in patient safety research

Patient safety culture

What is safety culture in healthcare?

How does safety culture influence patient safety?

Assessing patient safety culture

Improving patient safety culture

Patient involvement in patient safety and research

Patient safety culture and patient safety

Patient involvement in patient safety
Assessing patient involvement in patient safety
Improving patient involvement in patient safety
Patient involvement in research

Validation techniques of measurement tools to study patient safety culture in healthcare settings in Estonia Introduction to measurement properties, different types of validity and patient safety culture measurement instruments

An introduction on literature reviews

Translation process of measurement instruments and content validity

Construct validity

Hypotheses testing, cross-cultural validity and responsiveness

Applying knowledge and skills about validating safety culture instruments

Rationale for conducting literature reviews (what and why)

Steps in conducting a systematic review





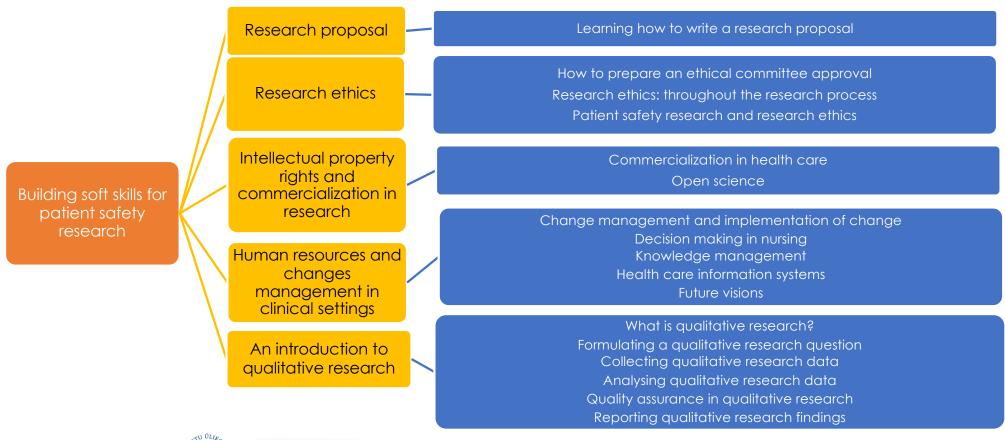


involvement in

patient safety

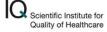
research

Module 3: Building soft skills for patient safety research









Methodology

- Workshops & preparatory activities for the workshops
- Video-lectures
- Forum exchange
- Activities: e.g. short questionnaires and quizzes, case analysis, personal reflections, articles critical discussions, writing a research plan, interactive activities
- Reading relevant papers
- Webinars with experts
- Self-study and final test or assignment

Basic and advanced versions

Chapter 2: Patient involvement in patient safety

This chapter is about the learning goal: Explain to your colleagues why patient involvement in patient safety is important

Aim of the chapter:

- · Participants can define the concept of patient involvement in healthcare practice
- · Participants can address the relevance involving patients in patient safety

Additional aim for advanced version students:

Participants can provide examples of patient involvement in patient safety on different levels in their own workplace on 1) direct patient care
and 2) the organization

In this chapter we have three paragraphs:

- 2.1 The concept of patient involvement
- 2.2 Levels of patient involvement
- 2.3 Patient involvement in patient safety

Chapter 2: What is safety culture in healthcare

This chapter is about the **learning goal:** Explain to your colleagues why safety culture is important for patient safety and how culture can affect patient safety

Aim of the chapter:

- · Participants are informed about the concept of culture in healthcare and know what safety culture is
- · Participants know the elements of safety culture in healthcare

In this chapter we have three paragraphs:

- 2.1 Organizational culture in healthcare
- 2.2 Culture or climate?
- 2.3 Safety culture in healthcare

 $\label{thm:continuous} \mbox{Workshop 1: the what and why on literature reviews and the first steps in performing a systematic review} \mbox{ and the first steps in performing a systematic review} \mbox{ and the first steps in performing a systematic review} \mbox{ and the first steps in performing a systematic review} \mbox{ and the first steps in performing a systematic review} \mbox{ and the first steps in performing a systematic review} \mbox{ and the first steps in performing a systematic review} \mbox{ and the first steps in performing a systematic review} \mbox{ and the first steps in performing a systematic review} \mbox{ and the first steps in performing a systematic review} \mbox{ and the first steps in performing a systematic review} \mbox{ and the first steps in performing a systematic review} \mbox{ and the first steps in performing a systematic review} \mbox{ and the first steps in performing a systematic review} \mbox{ and the first steps in performing a systematic review} \mbox{ and the first steps in performing a systematic review} \mbox{ and the first steps in performing a systematic review} \mbox{ and the first steps in the first steps in the first step in the first steps in the first step in the$

Aim of workshop 1

After following workshop 1 you will:

- know what literature reviews are
- understand the importance of literature reviews
- · have an overview of different forms of literature reviews and their differences
- understand the first steps in performing a literature review: identify a research question, selecting databases and developing the search strategy

Workshop overview

- 1. Preparatory activities
- Watching recorded videos

All the recorded videos are essential to watch and listen since they provide you with the knowledge necessary to accomplish the learning goals related to this course.

If you have any questions related to the lectures, please put them on the question forum and we will answer them as soon as possible.









Population-based review of medical records in 1992 HOSPITALS IN US STATES OF UTAH AND COLORADO

arnina methods:

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Contrary to a simplist

organizations are vie

theory indicates that non-linear, dyn

START

Active error

▶ 🤊

An error that occurs at the level of the frontline operator and whose effects are felt almost in

Active errors are generally readily apparent (e.g., pushing an incorrect button, ignoring a wa medicine)

Patient Safety Network: https://psnet.ahrq.gov/glossary

Comments (0)

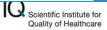
Adverse Event

Definition: An injury that was caused by medical management or complication instead of the

Example: Hip fracture due a fall in the hospital







HIGH RELIABILITY **ORGANIZATION?**

A high reliability organization (HRO) is characterized as one in which accidents rarely occur despite the error-prone nature of work. This infographic describes what characteristics of HRO a general hospital South Estonian Hospital (SEH) has and what it lacks.

PREOCCUPATION WITH FAILURE

Feedback and suggestions form

No system to report safety incidents

RELUCTANCE TO SIMPLIFY INTERPRETATIONS

0

• There are many outside experts that • As far as I know, safety incidents and work in both SEH and other hospitals errors are not systematically analyzed

and near misses

SENSITIVITY TO OPERATIONS

 Treatment manager is also an active
 Management doesn't actively look for hospitalist, seeing many problems first-hand

There are various possibilities to participate in trainings, including obligatory trainings

Daily hospital-wide briefings

Weekly, more in-depth briefings

unsafe behaviors/places in the hospital

 The culture doesn't allow correcting colleagues' unsafe behaviors



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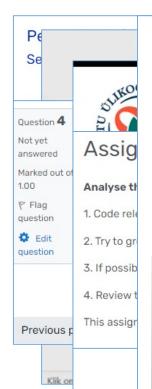
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mplex,

Examples of the activities and learning methods: Module 2

Ouestion 3 What is the 'I' (intervention in PICO) in this research question "What is the effect of 'patient safety leadership walk rounds' on patient safety culture in the hospital setting?" Not yet O Patient safety leadership walk rounds Marked out of Hospital setting O Patient safety culture P Flag question C Edit question Question 4 Not yet answered 1.00 question Edit Select one: question O True O False Question 5 Which database focuses on references from the nursing and allied health disciplines: Not yet PubMed Marked out of Web of Science 1.00 Embase Flag O CINAHL

Examples of the activities and learning methods: Module 3





Optional course module 2.1 An introduction to qualitative research

nd patients'



Gijs Hesselink

Postdoctoral research fellow IQ Healthcare Radboud university medical center

coordinator Mari Kangasniemi.

Interaction - What are your thoughts about the following patient safety research topics?

- Go to www.menti.com and use the code 46903151
 - An ideal Patient Safety Incidents Reporting System should: ...
 - Select one answer
 - A positive patient safety culture means to me: ...
 - Insert short answers
 - To what extent do you agree with the following statements on patient involvement: ...
 - o Agree, neutral, or disagree
 - The first thoughts that come to mind regarding research ethics in health care are: ...
 - Submit one answer, including one or more thoughts







Research stay in Barcelona (April dates, 2022)

- Addressed to early stage researchers
- Tailor the educational program to specific research interest
- In depth discussions with experts, focus time to writing papers, receiving feedback about own research, hospital visit.
- Main topics of discussion:
 - Measurement of adverse events
 - Implementation science
 - Systematic reviews and evidence maps of the literature
 - Trigger tools
 - Success factors of a Quality Improvement PhD

Participating partners

Strategic partnership with Avedic Donabedian Foundation (FAD) from Spain and IIQ healthcare (IQ HC) from the Netherland. Both international leaders in patient safety research, enables developing a long-lasting knowledge exchange alliamos allowing ICM-UT to capitalise on its current achievements and to overcome gaps in scientific excellence in the field of patient safety research.







_ocation

The program activities will be developed at:

Avedis Donabedian Research Institute

Provenza 293, Pral 08037

Barcelona



PATSAFE

Developing the University of Tartu to a well-networked PATient SAFEty research center in Estonia (PATSAFE)

Early stage researchers program Barcelona

4th-8th of April, 2022



The early stage researchers program is part of the training programme on patient safety research (PATSAFE project).

PATSAFE has received funding from the European Union's Horizon 2020, Coordination and Support Action programme, under grant agreement no 857359







Research stay in Nijmegen (May 18-20, 2022)

- Welcome to IQ healthcare, introduction & tour
- Time for discussion, writing, (peer) feedback about own research
- Meetings with experts in Radboudumc on:
 - Implementation research & quality improvement, obstetrics and gynaecology department
 - Patient involvement in practice and research (including the perspectives of a patient representative)
 - Incident reporting and analysis, prospective risk analysis (direct observation), patient safety policy and research, tour, Operating Theatre department
 - Patient safety culture in Radboudumc
 - Literature review, medical library
- department

16.00-17.00 h.

Mallory Woiski, MD, PhD, Obstetrician, Obstetrics & Gynaecology department Radboudumc (Geert Grooteplein 10, route 791)

3. Implementation research & quality improvement in the obstetrics and gynaecology 3. Incident reporting and analysis, prospective risk analysis (direct observation), patient safety policy and research, tour Operating Rooms department 13.30-16.30 h.

Anita Heideveld-Chevalking, RN, PhD, coordinator patient safety, Operating Rooms department (Geert Grooteplein 10, route 738)

Thursday, 19 May

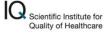
By bike to IQ healthcare, Radboudumo

1. Patient involvement in practice and research René Tabak, patient representative, chair Patient Advisory Board, Radboudumc Health Academy IO healthcare

DONABEDIAN | Scientific Institute for







RESULTS – number and experiences of students







Participants in each course

Module 1	Module 2	Module 3
The science of patient safety and the burden of unsafe care	Patient safety culture	Research proposal
70 students registered	52 students registered	13 students registered
25 certificates provided (10 advanced, 15 basic) 30 students active but haven't finished yet	13 certificates provided (9 advanced, 4 basic)14 students active but haven't finished yet	13 certificates provided
Methods of analysis of adverse events and improvement of patient safety (I)	Patient safety involvement in patient safety research	Research ethics
28 students registered	28 students registered	10 students registered
8 certificates provided (4 advanced, 4 basic) 10 students active but haven't finished yet	6 certificates provided (5 advanced, 1 basic)6 students active but haven't finished yet	8 certificates provided
Methods of analysis of adverse events and improvement of patient safety (II)	Validation techniques of measurement tools to study safety culture in Estonia	Intellectual property rights and commercialization in research
7 students registered.	32 students registered.	15 students registered
3 certificates provided (2 advanced, 1 basic)	11 certificates provided (5 advanced, 6 basic)	5 certificates provided
3 students active but haven't finished yet	14 students active but haven't finished yet	8 students active but haven't finished yet
Implementation science and patient safety improvement	An introduction on literature reviews	Human resources and change management in clinical settings
6 students registered to the online course	24 students registered.	65 students registered
4 students active but haven't finished yet	11 certificates provided (8 advanced, 3 basic)	30 certificates provided
	3 students active but haven't finished yet	32 students active but haven't finished yet
		Qualitative research methods 42 students registered.
		12 certificates provided
AVEDIS	10	12 students active but haven't finished yet







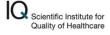
Satisfaction with the courses

- In each course, we included a 'Course assessment' questionnaire
- Mean grades range from 8 to 10 (Mean all courses: 8.7)

Module 1	Module 2	Module 3
The science of patient safety and the burden of unsafe care Mean grade (0-10): 8.1	Patient safety culture Mean grade (0-10): 8.3	Research proposal Mean grade (0-10): 8
Methods of analysis of adverse events and improvement of patient safety (I) Mean grade (0-10): 9.3	Patient safety involvement in patient safety research Mean grade (0-10): 8.4	Research ethics Mean grade (0-10): 9
Methods of analysis of adverse events and improvement of patient safety (II) Mean grade (0-10): 10	Validation techniques of measurement tools to study safety culture in Estonia Mean grade (0-10): 9	Intellectual property rights and commercialization in research Mean grade (0-10): 9.9
Implementation science and patient safety improvement Mean grade (0-10): 8.4	An introduction on literature reviews Mean grade (0-10): 8.7	Human resources and change management in clinical settings Mean grade (0-10): 8.7
		Qualitative research methods Mean grade (0-10): 8.6







Qualitative inputs: strenghts and improvement areas



- Professional and good quality video-lectures with experts
- Good course structure and coherence
- Good materials
- Reflection and practical tasks are well appreciated
- Cases and forum discussions

- Time consuming /demanding courses
- Too many courses at the same time
- Language issues
- More qualitative evaluation is needed (than quantitative approach)





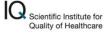


Lessons learnt

- Training needs vary among participants > more tailored approaches are needed
- Limited time
- All topics are relevant
- Early-stage researchers more interested in applied, local research
- Big opportunities for collaboration and cross learning among partners
- Twinning approach as excellent opportunity for making educational and research synergies







IMPACT – products, publications & abstracts, grant SAFEST and proposal Erasmus+







Products

- Tools, e.g.
 - a guide to perform root cause analysis
 - a framework for hospital safety culture
 - a guideline for preparing a research proposal

See toolbox on this website: PATSAFE | Välisveeb (ut.ee) including 14 tools

- Translated and validated questionnaires to assess patient safety culture:
 - Two questionnaires from the <u>healthcare staff perspective</u>:
 - the Hospital Survey on Patient Safety Culture (HSOPS)
 - the Safety Attitudes Questionnaire (SAQ)
 - One questionnaire from the patient perspective:
 - the OECD patient-reported incident measures (PRIMs) questionnaire







Publications

- Publications submitted:
 - PATSAFE: a Twinning project to strengthen patient safety research and training capability in Estonia
 - Identifying patient safety research priorities in Estonia–results of a Delphi consensus study
- Publications in progress:
 - Factors that facilitate and impede successful implementation of an educational program on patient safety research developed by a multinational and multicentered team
 - Students' experiences in learning about patient safety research
 - Development of a national patient safety strategy in Estonia
 - International Delphi study on research priorities in patient safety
 - Validation of the instruments to measure the safety culture in Estonian hospitals: questionnaires for patients and staff in two languages (Estonian and Russian)
 - Literature review: use of trigger tool in care of older patients







Abstracts in conferences

International Forum on Quality and Safety in Healthcare, 2021

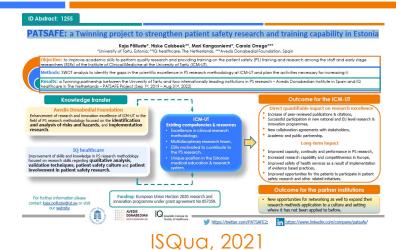




PATSAFE, a multi-country project to develop and implement a

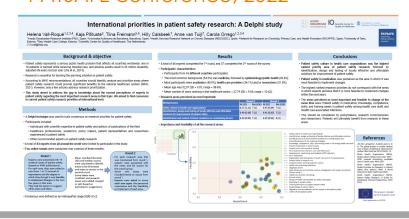


PATSAFE conference, 2022



International Forum on Quality

and Safety in Healthcare, 2022; PATSAFE conference, 2022









ISQua.

2021

Grant SAFEST

- Aim: To improve the adherence to evidence-based standardised patient safety practices in perioperative care by 15% and reduce the frequency of surgical complications by 8% after 18 months of a multicomponent intervention.
- Based on the broad support of European stakeholders, through a Perioperative Quality Improvement Learning Collaborative (PQILC), we will determine contextual factors (at macro-, meso- and micro-levels) that inhibit or promote the adoption of evidence-based practices and develop recommendations and lessons learnt to reduce knowledge-practice gaps.





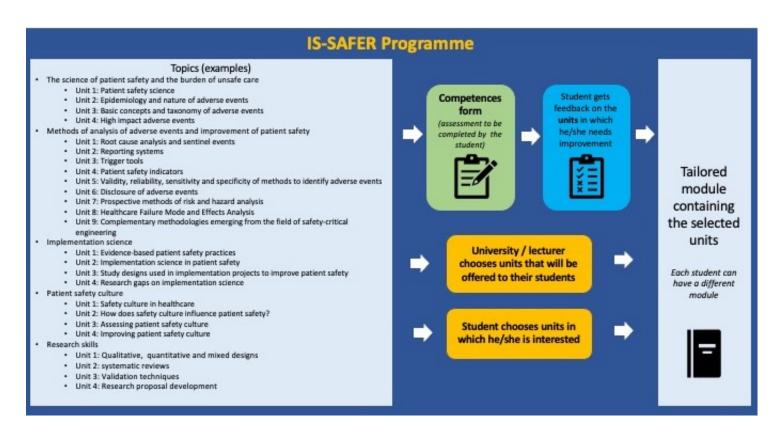


SAFEST project and results SAFEST standardized practices in perioperative care Dissemination and Communication **Exploitation and sustainability Self-evaluation of 10 hospitals in 5 European countries** Patient empowerment for perioperative patient safety Implementation of the SAFEST standardized practices **European Perioperative Quality Prioritisation and action Improvement Learning** planning in participating **Collaborative** hospitals Evaluation and monitoring patient safety in perioperative care Open self-evaluation on safety of perioperative care for hospitals internationally (EU27, associated countries and beyond)



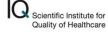
Proposal Erasmus+

- International School on patient SAFEty Research
- To create an online multilingual training programme in methods and techniques for patient safety research
- Intended as complementary modules for existing bachelor and master programmes in health sciences, quality management, etc.
- Accessible for also participants with chronic conditions or physical disabilities









DISCUSSION: sustainability & plans for the future





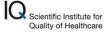


Sustainability & plans for the future

- Integration of some courses in existing curricula:
 - The course 'HR and change management in clinical setting' has been integrated twice (in two semesters) in the Nursing Sciences Master program
 - There is also interest in the Validation course, the Implementation Science course, and the Literature Review course
 - Some students <u>and</u> teachers from the same department have participated in the courses on Validation techniques, Qualitative Research, Literature Review, Ethics, etc.)
- Develop business case for future use of the courses
- Network of partner institutions, continue working together
- Learning from the PATSAFE educational development and open it to a wider audience
- Erasmus+ proposal: develop smaller learning units based on the PATSAFE courses in English, Estonian, Spanish and Dutch for use in several existing bachelor and master curricula







PATSAFE COURSES STILL OPEN UNTIL AUGUST 2022!







Thank you





