Plano Nacional
para a Segurança
dos Doentes
2021 | 2026

Technical Document for the Implementation of the National Plan for Patient Safety

2021 | 2026

REPÚBLICA PORTUGUESA
SAÚDE

SNS
SERVIÇO NACIONAL DE SAÚDE

DGS desde 1899
Direção-Geral da Saúde

Technical Data Sheet
Portugal. Ministry of Health. Directorate-General of Health.
Title
Technical Document for the implementation of the National Plan for Patient Safety 2021-2026
Editor
Directorate-General of Health
Alameda D. Afonso Henriques, 45
1049-005 Lisbon

Authors
Ana Lebre
Ana Resendes
Artur Paiva
Carla Barbosa
Carla Pereira
Filomena Gaspar
Goreti Silva
Isabel Oliveira
Margarida Eiras
Margarida Valente
Maria João Gaspar
Marta Nunes
Miguel Arriaga
Paulo Sousa
Pedro Pacheco
Sofia Costa
Susana Ramos
Válter Fonseca

Lisbon, May 2022

List of Acronyms and Abbreviations

ACES	Groups of primary care centres
ACS	Safety Culture Assessment
ACSS	Central Administration of the Health System
AMR	Antimicrobial Resistance
APDH	Portuguese Association for Hospital Development
ARS	Regional Health Administration
ASP	Antimicrobial Stewardship Programs
CQS	Quality and Safety Committees
DGS	Directorate-General of Health
DQS	Department for Quality in Health
ENQS	National Strategy for Quality in Health
ENSP/NOVA	National School of Public Health - Nova University
ESEL	Nursing School of Lisbon
EU	European Union
GPSAP 2021-2030	Global Patient Safety Action Plan 2021-2030
HAI's	Healthcare Associated Infections
HAM	High Alert Medicines
INFARMED	National Authority for Medicines and Health Products
INSA	National Health Institute Doutor Ricardo Jorge
IPST	Portuguese Institute of Blood and Transplantation
LASA	*Look-Alike Sound-Alike medicines*
MoH	Ministry of Health
MRSA	Methicillin-resistant Staphylococcus aureus
MS	Member States
NOTIFICA	National Incident Reporting System
PHC	Primary Health Care
PNSD 2015-2020	National Plan for Patient Safety 2015-2020
PNSD 2021-2026	National Plan for Patient Safety 2021-2026
PNS	National Health Plan
PPCIRA	National Program on Prevention and Control of Infection and Antimicrobial Resistance
SNNIEA	National Incident and Adverse Events Reporting System
SNS	Portuguese National Health Service
SPMS	Shared Services of Ministry of Health
SSC	Surgical Safety Checklist
ULS	Local Health Units
WHO	World Health Organisation

Foreword

As the Directorate-General of Health is the technical-normative body of the Ministry of Health, it is exclusively responsible for determining the rules for the safe and quality provision of health care in the public and private sectors, i.e. in the National Health Service in particular and in the Health System in general.

Aware of the priority that must be given to ensuring the quality and safety of health care in 2009 the Ministry of Health created the Department of Quality in Health within the Directorate-General of Health, with the main objective of coordinating the National Strategy for Quality in Health, which integrates the National Plan for Patient Safety.

When we talk, somewhat reductively, about patient safety, we are talking about the safety of healthcare provision, i.e. the safety of patients, of health professionals and of the environments in which care is provided.

While it is true that the improvement in the quality of healthcare is mainly measured by the gains obtained in the efficiency and effectiveness of its provision, it is indisputable that these gains will only be significant if its safety is improved.

This is the reason why the assessment of the National Plan for Patient Safety 2015-2020 was fundamental and, was at the basis of the creation of the Plan for 2021-2026 period. All health professionals, service directors, clinical directors, nursing directors, managers and administrators of the primary health care and hospitals have the duty to comply with, respecting the technical guidance of the Directorate-General of Health (DGS). It is also the responsibility of the professional associations and health science faculties to collaborate with it.

This National Plan for Patient Safety 2021-2026, while continuing the previous one, has an innovative approach of its strategic and programmatic axes and will certainly demonstrate, through its future evaluation, that the gains with the quality and safety in the provision of health care are a step by step course. With coherence and persistence and with the involvement and commitment, in a systemic manner, of all and for the good of all.

- J. Alexandre Diniz

Through the National Plan for Patient Safety 2021-2026, the Directorate-General of Health is consolidating the paths taken in terms of Patient Safety. This path towards a safer health system and National Health Service is only possible due to the in-depth dialogue between all those working on patient safety on a daily basis, and due to the collaborative and multi-sectoral work.

The National Plan for Patient Safety 2021-2026 respects the history of Patient Safety in Portugal and the legacy of all its stakeholders. A Plan based on a rigorous evaluation of the lessons learned from the National Plan for Patient Safety 2015-2020.

A Plan which, in line with the World Health Organization's Global Patient Safety Action Plan 2021-2030, accomplishes the challenge of that Organization to establish patient safety as a priority for health policies.

A Plan integrated with the health policies and strategies, regarding quality and safety, including the National Health Plan and the Health Programmes, and in particular the Programme for the Prevention and Control of Infections and Antimicrobial Resistance. In the advent of Quality and Innovation, the vision - of this Plan - is clear: a safer health system and National Health Service, and with more quality!

Alea jacta est!

- Válter R Fonseca | Director of the Department of Quality in Health

Executive Summary

Within the scope and competencies of the Department for Quality in Health (DQS) of the Directorate-General of Health (Order no. 1250/2020, of the 28th of January), was published the National Plan for Patient Safety 2021-2026 (PNSD 2021-2026) under the Order no. 9390/2021, of the 24th September.

Also according with the continuous improvement perspective, it is hereby published the Technical Document for the implementation of the PNSD 2021-2026. This document which continues the experience with the previous Plan and to deepen the fundamentals underlying the PNSD 2021-2026. It also sustains its operationalization, the basis for the evenness of the implementation processes and for the consecution of its goals and objectives, thus easing the work of all the professionals and managers within the patient safety area. The PNSD 2021-2026 and the present Technical Document are a contribution to achieve the success of the health, quality and patient safety policies, a higher good to all those who directly or indirectly participate, in a Health System, in a National Health Service and in Portugal.

This document results from the participation and involvement of the many different authors implicated in the design, implementation, monitoring and evaluation of the PNSD 2015-2020, whether regarding the planning and construction of the PNSD 2021-2026 in a model of definition of policies and strategies in a participatory and collaborative model of definition of policies and strategies, under the coordination of the DQS , of Directorate-General of Health.

This is the also the endeavour of the Order no. 9390/2021 of the 24th of September: the publication of the present Technical Document which must be available to all those who might need it, in a process that cannot be isolated from the relevant mechanisms and tools allowing the continuous training of the health care professionals and stakeholders in order to provide the patients with a safe and adequate health system, and also a health service that is based on scientific evidence and human values and on the continuous quality assessment.

Partnerships and Acknowledgements

- Central Administration of the Health System, I.P (ACSS, I.P.);
- Regional Health Administration (ARS);
- Portuguese Association for Hospital Development (APDH);
- National Authority of Medicines and Health Products (INFARMED, I.P.);
- Executive Coordination of the National Health Plan of the Directorate-General of Health;
- Quality and Safety Committees (CQS) of SNS health institutions;
- Division of Communications and Public Relations of the Directorate-General of Health;
- Division of Literacy, Health and Well-being of the Directorate-General of Health;
- National School of Public Health (ENSP), under the Collaboration Protocol with the DGS;
- Nursing School of Lisbon (ESEL), under the Collaboration Protocol with the DGS;
- Portuguese Institute of Blood and Transplantation (IPST, I.P.);
- National Program on Prevention and Control of Infection and Antimicrobial Resistance (PPCIRA), at DGS;
- Shared Services of Ministry of Health (SPMS, E.P.E.).
- Aidan Fowler (National Health Service, UK); Alexandra Antunes (National Board of the Psychologists' Association); Ana Luísa Gomes (DQS); Ana Paula Martins (Pharmacists' Association); Ana Sanches (Family Health Unit Ribeira Nova); André Coelho (Lisbon School of Health Technology -ESTESL); Angelina Francisco (Portuguese Nurses' Association); Carla Barbosa (Faculty of Law - University of Coimbra); Carlos Henriques (District Hospital of Santarém); Cristina Nunes (Northern Local Health Unit); Dulce Diogo (Portuguese Medical Association); Elsa Ramos (North Regional Health Administration); Fernando Barroso (Setúbal Hospital Centre); Fernando Leal da Costa (ENSP-NOVA); Filipa Paixão (Integrated Continued Care Teams Oriente - Personalized healthcare unit Olivais); Filomena Gaspar (Lisbon Nursing School); Hugo Esteves (ACES Loures Odivelas); Isabel Guerra (Portuguese Physiotherapists' Association); Joana Faro (Tondela-Viseu Hospital Centre); José Artur Paiva (Director, PPCIRA); José Camolas (Portuguese Nutritionists' Association); José Fragata (ENSP-NOVA); Júlio Bilhota Xavier (Portuguese Society of Paediatrics - SPEQS); Luísa Nunes (Northern Local Health Unit); Luiziane Pereira (ENSP-NOVA); Manuel Oliveira (Centre Regional Health Administration) Margarida Eiras (Portuguese Association for Hospital Development); Maria João Lobão (ENSP-NOVA); Maria José Barros (Mello Saúde Group); Marta Nunes (HCG Central Lisbon-East UCC); Miguel Castelo-Branco (Faculty of Health Sciences, University of Beira Interior); Neelam Dhingra-Kumar (WHO); Paulo Boto (ENSP-NOVA); Paulo Sousa (ENSP-NOVA - UNL); Rosa Ribeiro (Setúbal Hospital Centre); Rute Miranda (Barreiro-Montijo Hospital Centre); Sofia Paiva (ENSP-NOVA); Susana Ramos (University Hospital of Central Lisbon); Susana Vargas (University Hospital of São João); Virna Ustá (Department of Public Health – Lisbon and Tagus Valley Regional Health Administration); Yolanda Agra (Ministry of Health - Spain).

INDEX

1. Framework

Patient safety has emerged as a central issue on the agendas of many countries in Europe and around the world over the last two decades and is now internationally recognised as a fundamental component of quality in healthcare.

The World Health Organization (WHO) and the European Union (EU) have begun building patient safety by defining guidelines and policies, along with projects and financing programmes, urging countries to participate in this movement on a global level.

It is, therefore, important to define priorities, targets and actions, and identify who does what (responsibility), how, when and with what means. In summary, it is essential to strategically plan and monitor the implementation of the PNSD 2021-2026 so that the actions can be aligned, resources can be optimized and health gains can be enhanced, with special focus on patient safety.

When, in 2002, the WHO placed patient safety on the world agenda, the epidemiological surveillance activities of the National Programme for Infection Control (created in 1988 in Portugal and currently part of the DGS's National Program on Prevention and Control of Infection and Antimicrobial Resistance - PPCIRA), the quality improvement projects developed in hospitals embodied the patient safety initiatives at national level.

In Portugal, patient safety has become part of the national agenda, when it was defined as one of the priorities for improving organisational quality in the DGS's National Health Plan 2004-2010 (PNS).

During the 2004-2010 PNS, the national planning and coordination for quality in health and safety in the provision of care became part of the DGS's responsibilities through the DQS.

1.1. National Plan for Patient Safety 2015-2020

The publication of the National Strategy for Quality in Health (ENQS), through the Order No. 14223/2009, of 24 June and Order No. 5613/2015, of 27 May, which as a strategic priority integrated the National Plan for Patient Safety 2015-2020 (Order No. 1400-A/2015, of 10 February), provided a framework for the structural development of patient safety in Portugal.

The local governance structure for patient safety, created by Order No. 3635/2013, of 7 March, which trough the Quality and Safety Committees (CQS) enabled both the operationalisation of the actions recommended in the ENQS and in the PNSD at the different levels of care, and ensured the dissemination and implementation of the recommendations and guidelines issued by the DGS.

The DGS, through the DQS, joined, early on, the international initiatives and projects in the area of patient safety, highlighting:

- In 2008/09, the adherence to the global challenges of the WHO's World Alliance for Patient Safety, was firstly directed for the prevention of infections and resistance to antimicrobials through the hand hygiene and secondly for the reduction of adverse events during surgical care, through the "Safe Surgery Saves Lives" programme, as recommended in Guideline No. 02/2013.

- The participation, between 2008 and 2010, in the European Network for Patient Safety (EUNeTPAS) project. This was a collaborative network of the 27 EU Member States, international organisations and stakeholders (health professionals, patients, institutions and researchers) for patient safety, which enabled advances in the patient safety culture, and in continuous education and training, by issuing recommendations on medication safety and in sharing the advances of technological platforms for patient safety incidents.

- In 2012, the translation and publication of the WHO's "Conceptual Framework for the International Classification for Patient Safety", a reference document for the use of common terminology for reporting, researching and

learning from safety incidents.

- In 2012, the DGS made available the National Incident and Adverse Event Reporting System (SNNIEA), an anonymous, confidential and non-punitive system for the management of adverse incidents and events, which was accessible to health professionals and citizens. With a view to improving the SNNIEA, the DGS made changes to this platform in 2013, which evolved into the National Incident Reporting System (NOTIFICA), as set out in Guideline No. 015/2014. This cost free incident reporting and management system aims to identify the causes of incidents or adverse events in health care, in order to take the necessary systemic corrective measures, at local and national levels, allowing to learn from errors, while maintaining the non-punitive nature and the confidentiality of the person reporting.

The DGS, through the DQS, coordinated the preparation and published the guidelines in the main areas of patient safety, namely the: Identification and Risk Assessment of Pressure Ulcers (Guideline No. 017/2011); Patient misidentification (Guideline No. 018/2011); Analysis of incidents and adverse events (Guideline No. 011/2012); Safe surgery (Guideline No. 02/2013); Assessing the safety culture in hospitals (Guideline No. 025/2013 and No. 005/2018) and in primary health care (Guideline No. 03/2015); Look-alike or sound-alike (LASA) medication names (Guideline No. 020/2014); High-alert medications (Guideline No. 014/2015); Medication management process (Guideline No. 014/2015); Medication Reconciliation (Guideline No. 018/2016); Effective communication in the transition of care (Guideline No. 001/2017) and Prevention and intervention in adult falls in hospital care (Guideline No. 008/2019).

The PNSD 2015-2020 defined the actions to be developed at local and central levels in terms of patient safety. Considered as a support tool for managers and health professionals regarding the implementation of best safety practices, it was based on 9 strategic objectives:

1. Increasing the safety culture in the internal environment
2. Improve communication
3. Improve surgical safety
4. Improve safety in medication use
5. Ensure the patient misidentification
6. Prevention of falls
7. Preventing the occurrence of pressure ulcers
8. Ensuring the systematic practice of incident report, analysis and prevention
9. Prevention and control of infections and antimicrobial resistance

To achieve these objectives, the PNSD 2015-2020 identified the timetable of actions to be carried out by the many national stakeholders: Directorate-General of Health, Central Administration of the Health System, Shared Services of the Ministry of Health, National Authority for Medicines and Health Products, Health Care Centres, Hospital Centres, Hospitals and Local Health Units.

BACK TO INDEX

Alongside the activities set out in the PNSD 2015-2020, the DGS has also developed other initiatives and projects, using partnerships, which are considered an added value, given the needs and challenges for the patient safety area, in particular:

- Development of awareness-raising actions within the scope of the safety culture assessment;
- Coordination of the Pilot Project "Health Care Safety Literacy in Portugal" (Order No. 6430/2017, of 25 July), aimed at citizens;
- Production of courses in the Massive Open Online Courses (MOOC) format;
- Celebrating the World Patient Safety Day, promoted by the WHO, by using several initiatives in collaboration with the CQS.

Finally, it is important to mention that the building of patient safety in Portugal would not have been possible without the collaboration of the Ministry of Health, Academia, Patients' organisations, healthcare institutions, health professionals, professional associations and CQS.

The DGS intends to continue and to strengthen these collaborations, as this is the only way to achieve the objectives set in the PNSD 2021-2026 and to reinforce patient safety in Portugal.

1.2. Assessment of the National Plan for Patient Safety 2015-2020 (PNSD 2015-2020)

Monitoring the implementation and assessing the results of the PNSD 2015-2020 had the collaboration of researchers and collaborators from the DGS's partner institutions, such as the Nursing School of Lisbon, through the Department of Nursing Administration and the Nursing Research and Development Centre, and the APDH. These partnerships were essential for an independent analysis and critical reflection, which was necessary for the design of the current PNSD 2021-2026.

The summary bellow presents the assessment of the 9 strategic objectives in the PNSD 2015-2020, and it is the result from the periodical evaluation of the online form collected data, by the CQS, and the Safety Culture Assessment questionnaire.

Strategic Objective1 – Increase the safety culture in the internal environment

Within the Safety Culture Assessment (ACS), the Strategic Objective 1 assessment took place in even years in Hospitals (Guideline No. 025/2013 of 24 December, and respective updates of 20 January and 19 November 2015 and Guideline 005/2018 of 20 February and update of 10 January 2020). The assessment of the PHC facilities took place in odd years, in PHCs (Guideline No. 003/2015 of 11 March and respective updates of 06 February 2017 and 13 February 2019).

The ACS results from a questionnaire, composed of 42 items, assessing 12 dimensions of the patient safety culture (Table 1) to which professionals and employees of healthcare institutions were asked to answer.

Dimensions
1. Teamwork within units
2. Supervisor/manager expectations and actions promoting patient safety
3. Management support for patient safety
4. Organisational learning - continuous improvement
5. Overall perceptions of patient safety

6. Feedback and communication about error
7. Communication openness
8. Frequency of events reported
9. Teamwork across units working
10. Staffing
11. Handoffs and transitions
12. Non-punitive response to errors

Table 1– Dimensions of the ACS

Regarding the statistical analysis plan, the methodology followed was that proposed by the Agency for Healthcare Research and *Quality*[1] by recoding the scale, with the percentage of specific positive answers in the dimension or item being the main analysis indicator.

In the ACS conducted in Hospitals (2014-2020), the following results stand out.

- The national adherence rate (Chart 1) was:
  - 18.3%, in 2014, with the participation of 55 units and 17,928 professionals;
  - 18.5% in 2016, with the participation of 61 units and 18,938 professionals;
  - 14.9% in 2018, with the participation of 65 units and 17,205 professionals;
  - 13.8% in 2020, with the participation of 38 units and 7,360 professionals.

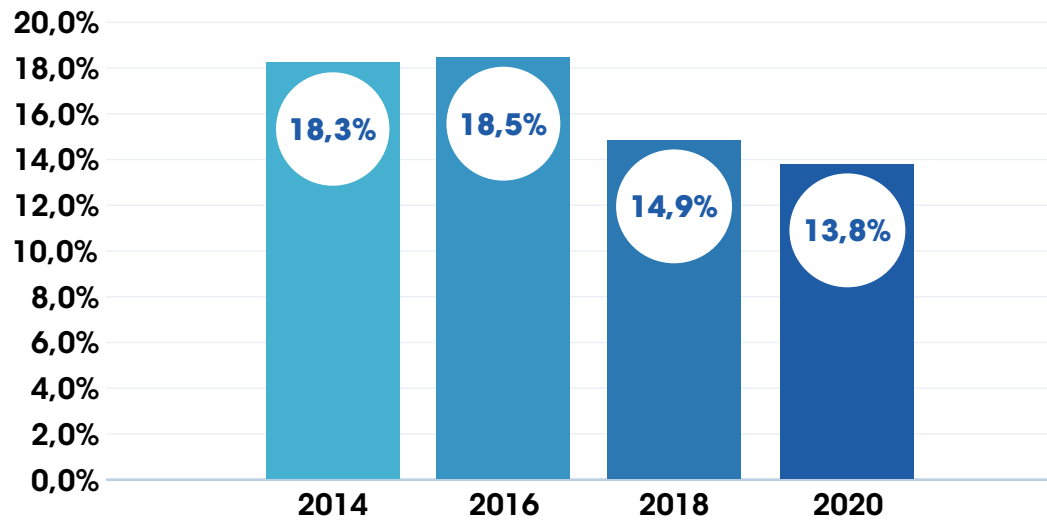

Chart 1- Evolution of the national adherence rate in hospitals (Patient Safety Culture Assessment Questionnaire in Hospitals)

- The teamwork within units dimension presented the highest percentage of positive answers in all hospitals, always above 50%, varying between 60% and 83%;

1 *Sorra J.; Nieva V.F. Hospital Survey On patient safety culture. Agency for Healthcare Research and Quality – AHRQ. 2004; 04-0041*

BACK TO INDEX

- Throughout the 4 assessments, it should be noted that the dimensions Staffing and Non-punitive response to errors were those with the lowest percentage of positive answers in all hospitals under analysis (below 50%).The dimension Frequency of events reported had a 50% plus response in only one hospital.

The findings in hospitals are the reporting culture is still weak which may reflect, among other reasons, the fear of punitive measures or reputational damage. Although the safety culture assessment had the participation of a significant number of public hospitals and, though in smaller numbers, of private hospitals, the national adherence rate was low, which may reveal the need to further promote and disseminate the importance of safety culture and its assessment among health professionals, institutions, managers and patients.

In the ACS carried out in the Primary Health Care (2015 - 2019), the following results stand out (Chart 2)::

- The national adherence rate had a positive evolution and was:
  - 20.1% in 2015, with the participation of 54 units and 4,596 professionals;
  - 32.2% in 2017, with the participation of 52 units and 7,299 professionals;
  - 35.1% in 2019, with the participation of 52 units and 9,461 professionals.

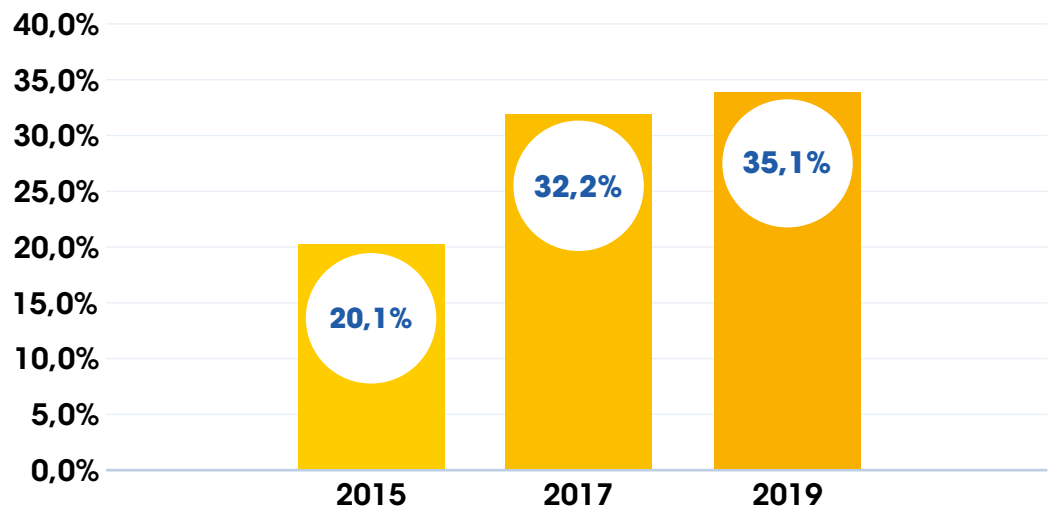

Chart 2- Evolution of the national adherence rate in PHC (Patient Safety Culture Assessment Questionnaire in Primary Health Care)

- The Teamwork within units' dimension presented the highest percentage of positive answers in all units, always above 50%, and varying between 58% and 100%;
- The areas with most opportunities for improvement were: Stress and work rhythm; Support by senior management and Training and coaching of professionals.

So, it is understood that the variation in the results across the different dimensions provides a learning and intervention opportunity for the health care units, thus contributing to the process of continuous improvement, which is so urgent given the current challenges imposed by the new models of health care provision, which are now increasingly more demanding.

Strategics Objectives 2 to 9

Regarding the strategic objectives 2 to 9, a form was applied, available on the DGS website and completed every year by the CQS, with questions aimed at evaluating good practices and the goals to be achieved by the institutions in the SNS.

For the 2015-2019 period, the responding institutions varied between 82 and 93 (Table 1), in a universe of 95 existing institutions (49 Hospitals and 46 ACES).

	2015	2016	2017	2018	2019
Total Responding Entities	82	93	90	92	84

Table 1 – Number of responding entities to the CQS form

Strategic Objective 2 - Improve communication

With regard to improving communication, 64,869 audits were carried on regarding communication during handoffs and transitions, in accordance with Guideline No. 001/2017.

Strategic Objective 3 – Improve surgical safety

This strategic objective had the following targets: "1) Use the Surgical Safety Checklist (SSC) in 95% of surgeries; 2) Reduce the non-compliance rate in the use of the SSC by 5% compared to the previous year; 3) Reduce the rate of never events in surgery by 1% annually". However, it was verified the existence of institutions that still do not use the SSC.

Finally, the annual evolution of the average non-compliance rate in the use of the SSC (Chart 3) reinforces the importance of continuing with the objectives and goals of the PNSD 2015-2020.

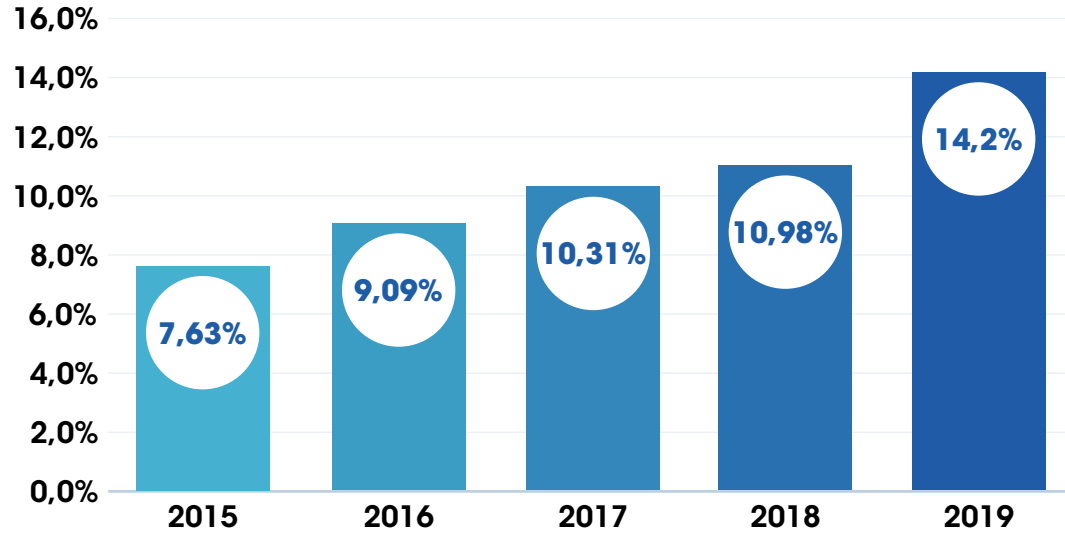

Chart 3 - Annual evolution of the average non-compliance rate in the use of the SSC (2015-2019)

Strategic Objective 4 - Improve safety in medication use

With regard to this strategic objective, the goals were: "1) 90% of healthcare institutions implementing safe medication practices in accordance with the national Guidelines; and 2) Reduce by 50% each year, compared to the previous year, the number of medication errors related incidents in the SNS institutions' or institutions with conventions".The results showed an increase in the number of institutions implementing safe practices.

In 2019, the number of institutions with implemented measures within the medication safety practices corresponded to 72%.

The increase in safe practices regarding look alike sound alike medicines (LASA) is noteworthy; in 2015, 95% of the institutions had an updated and disclosed LASA list and, in 2019, this figure was 92.9%. As for the high alert medications (HAMs), in 2015, 24% of the institutions had an updated HAMs' list and, in 2019, this figure increased to 90.47%.

The number of reports, although not very significant, corroborates the safety in medication use for the safety culture.

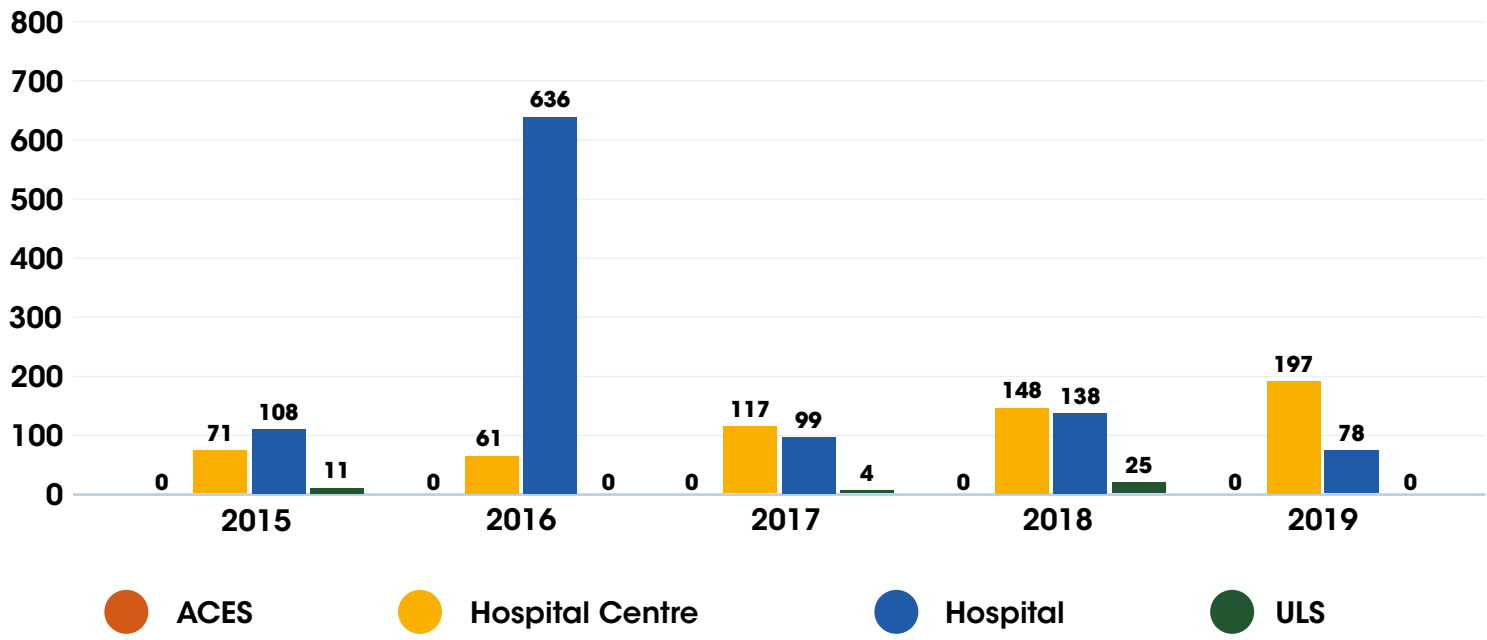

Chart 4 - Annual evolution: Number HAMs incident reports (2015-2019)

Strategic Objective 5 - Ensure the patient misidentification

This objective had the following goal: "95% of healthcare institutions with safe practices for the identification of patients implemented", a positive evolution was noted in the number of institutions with implemented strategies for patient misidentification, corresponding in 2019 to 91.7% of the institutions.

The reports of related incidents to patient identification showed a downward trend, although with some variability due to the fluctuation in the number of responding institutions over the years (Chart 5).

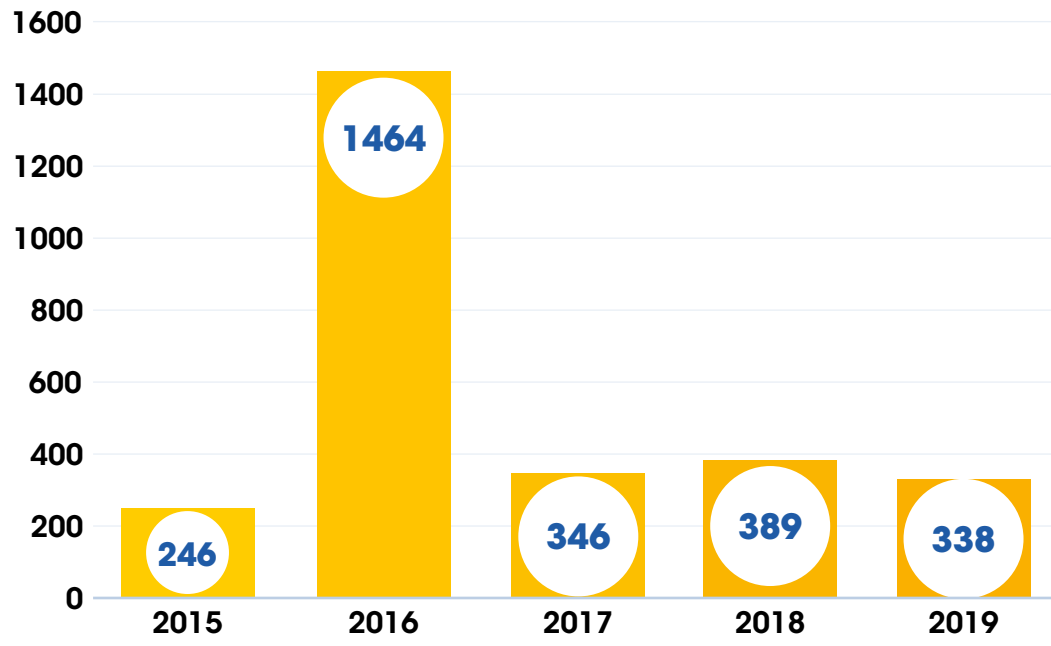

Chart 5 - Annual evolution on the number of incident reports with unambiguous identification of patients (2015-2019).

Note: In the year 2016, there were 1464 reports, with 1124 reports from one single health institution.

BACK TO INDEX

Strategic Objective 6 - Prevention of falls

This objective had the following : "1) 95% of the health care institutions with fall prevention and reduction practices implemented; 2) Reduce by 50% each year, in relation to the previous year, the number of falls in SNS or institutions with conventions". The results showed that, in the hospital units, the implementation of fall prevention activities varied from 94.7% in 2015 to 100% in 2019, thus meeting the respective target. In the ACES, the increase in the risk assessment for the prevention of falls at home stood out (89.50%; 2019), with the consequent increase in reporting.

As for the falls related reports, there was an increase over the years, with the exception of 2017, with the reduction of reports. In 2019, there were 9124 reports of falls, thus marking an upward trend associated with the number of audits and reports (Chart 6).

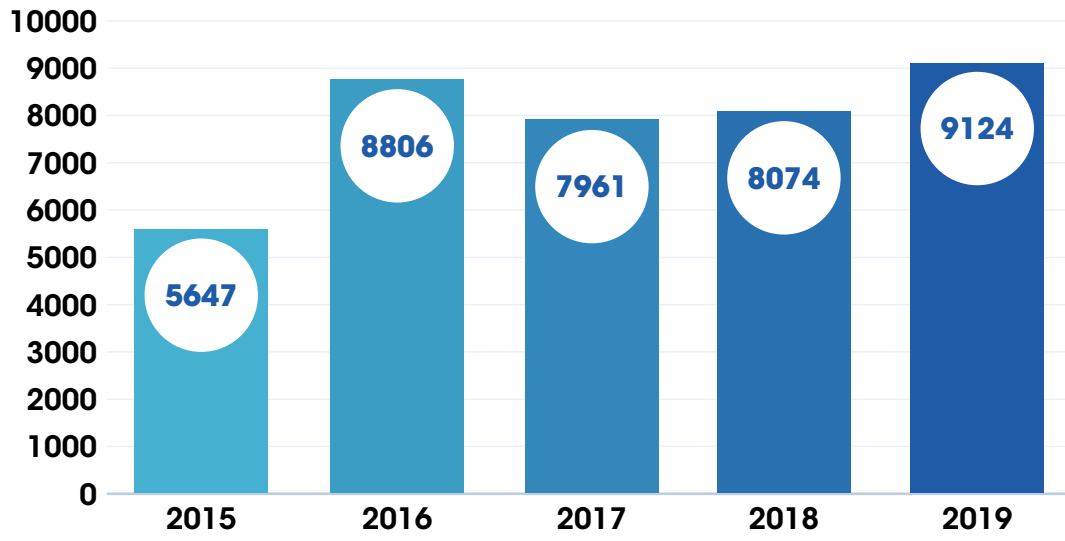

Chart 6 - Annual evolution: total number of falls' reported (2015-2019)

Strategic Objective 7 - Prevent the occurrence of pressure ulcers

The goals for this strategic objective were: 1) "95% of healthcare institutions with implemented practices to assess, prevent and treat pressure ulcers; 2) Reduce by 50%, in relation to 2014, the number of pressure ulcers (PUs) developed in the SNS or institutions with conventions."

It was found that a significant number of healthcare institutions implemented practices to assess, prevent and treat PUs. In 2019, this figure varied between 82.9% and 90.5% of the total number of healthcare institutions. Between 2015-2019, there was an increasing number of reported incidents of PUs (Chart 7).

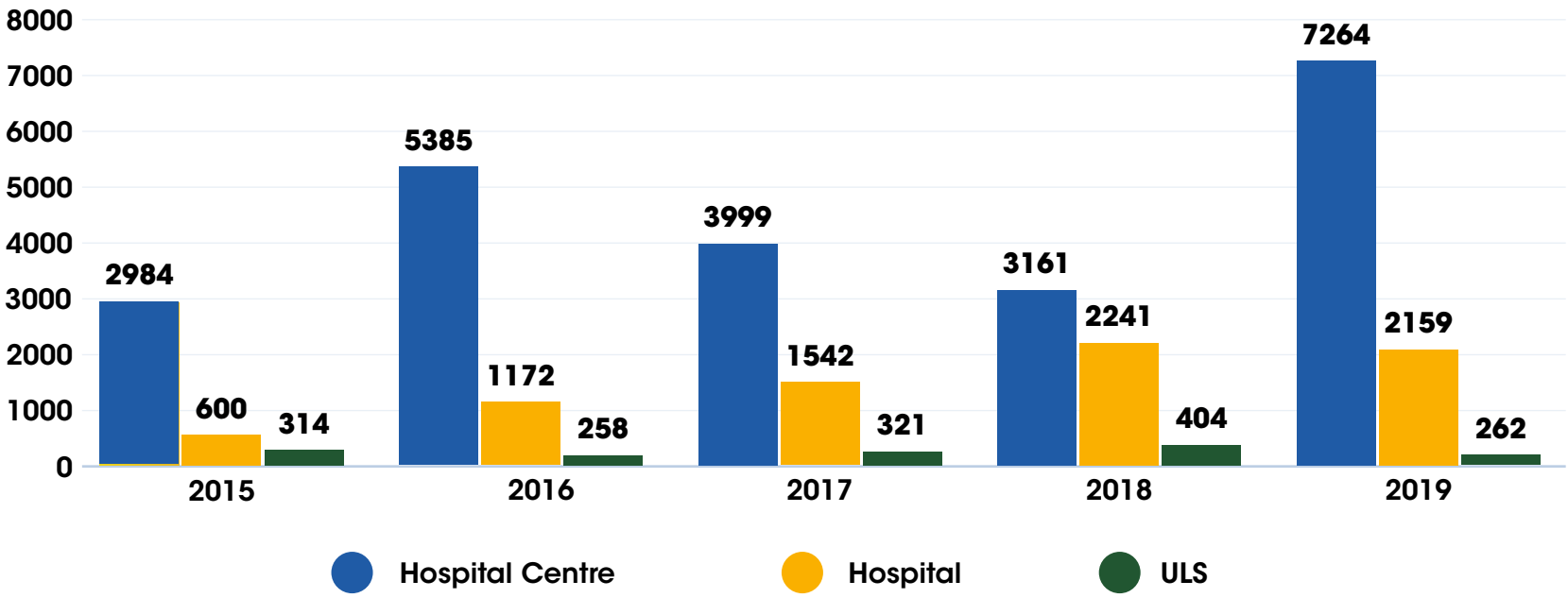

Chart 7 - Annual evolution of PU reports per incidents/type of entity (2015-2019)

BACK TO INDEX

Strategic Objective 8 - Ensure the systematic practice of incident report, analysis and prevention

The goal of objective 8 was: "Increasing, by 20% per year, the number of safety incident reports in the NOTIFICA system". Based on the figures reported by the CQS, it was found that the 20% target was attained, with 58.8% between 2017-2018 and 30.4% between 2018-2019, also noting the growing reporting by the citizen, especially in the last year. It should be noted that the institutions indicated the frequent use of other safety incident reporting systems (Chart 8), making the interoperability of these information systems fundamental for an accurate data representativeness at national level.

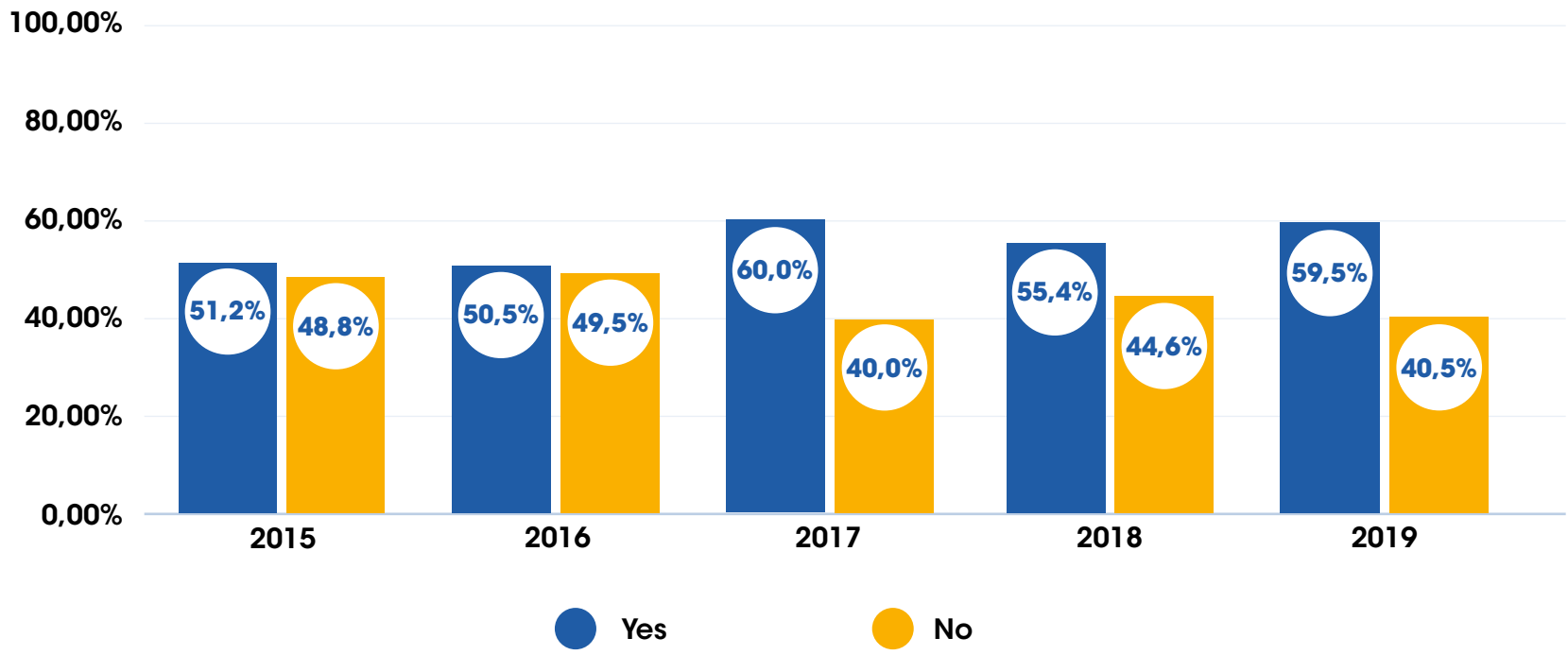

Chart 8 - Annual evolution of information using another report system (other than NOTIFICA)

Strategic Objective 9 - Prevention and control of infections and antimicrobial resistance

This strategic objective whose targets were: "1) Attaining a hospital infection prevalence rate of 8%; 2) Reducing antimicrobial consumption by 50% compared with 2014; 3) Attaining a MRSA rate of 20%; 4) Reducing carbapenem consumption by 50% compared with 2014; 5) Reducing quinolone consumption by 50% compared with 2014", was evaluated by PPCIRA.

With regard to monitoring of Healthcare Associated Infections (HAIs), most institutions did so, highlighting an increase by 2018 (80.9%) and a slight decrease in 2019 (76.1%).

The annual evolution of antimicrobial consumption allows us to ascertain that the highest reporting value was in 2016 (90.3%), while in 2019, the value was 84.5%, showing a 50% reduction in the consumption of antibiotics, compared to 2014.

As for the rate of methicillin-resistant Staphylococcus aureus (MRSA), calculated by 1000 inpatient days/outpatients, more than 50% of the institutions informed to have achieved this objective. A decrease in carbapenem consumption was noted, as intended.The institutions' favourable responses ranged from 41.1% (2017) to 80.4% (2019).The decrease in quinolone consumption was also reported by most institutions, with the values varying between: 73.6% and 90.6% in 2018, and 86.7%, in 2019.

As for the results concerning the preparation of an action plan for the prevention and control of infections and antibiotic resistance and prescription of antimicrobial drugs (2017-2019), most institutions responded favourably, with a minimum of 77.5% in 2017 and a maximum of 81.5% in 2018 (Chart 9).

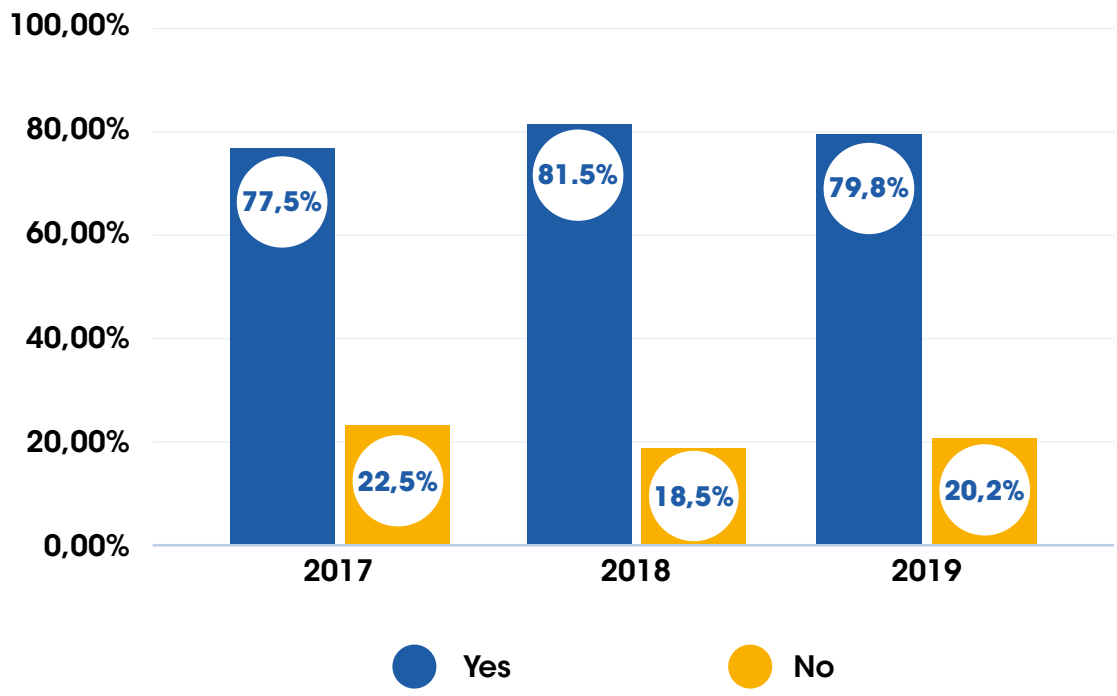

Chart 9 - Annual evolution, development of an action plan for the prevention and control of infections and antibiotic resistance and prescription of antimicrobials (2017-2019)

Conclusion

The PNSD 2015-2020 was an important tool for the increase of patient safety in Portugal and, throughout its duration, the following stands out:

- the publication of guidelines in all areas of the patient safety;
- the increase in the number of audits carried out, in all areas;
- the increase in the reporting of incidents and the evaluation of good practices.

The evaluation of the PNSD 2015-2020 has made it possible to identify:

- the need to deepen and consolidate the safety culture, particularly regarding the no blame culture and raising awareness for the importance of reporting the incidents;
- the need for the interoperability of the information systems;
- the need to continue the objectives of the PNSD 2015-2020 across the organisations, and
- the opportunity to adapt instruments and tools to the new needs and challenges in the patient safety area.

1.3. Global Patient Safety Action Plan 2021-2030

The Global Patient Safety Action Plan 2021-2030 (GPSAP 2021-2030)[2], adopted by the WHO, envisions a world where there are no healthcare-related harms and where safe, tailored, respectful care is provided to all patients throughout the life cycle. The mission of the GPSAP 2021-2030 is to push for:

- the development of policies, strategies and actions, based on scientific evidence and patient experience;
- the development and design of systems and partnerships to eliminate all possible sources of risk and avoidable harm to patients and health professionals;

2 World Health Organisation. Global Patient Safety Action Plan 2021–2030: towards eliminating avoidable harm in health care. Geneva: World Health Organization; 2021.

- the reduction, to the greatest extent possible and on a global scale, of avoidable harm resulting from unsafe healthcare.

To guide the development and implementation of the proposed framework for action in this strategic document, seven guiding principles were defined:

1. Engage patients and families as partners in safe care;
2. Achieve results through collaborative working;
3. Analyse and share data to generate learning;
4. Translate evidence into actionable and measurable improvement;
5. Base policies and action on the nature of the care setting;
6. Use both scientific expertise and patient experience to improve safety;
7. Instil a safety culture in the design and delivery of health care.

One of the key aspects of the GPSAP is the importance of the intervention of the different stakeholders and the need to create synergies and foster partnerships. The key partners are: i) the governments of each country: ministries of health and all those whose activities impact on patient safety, legislative, regulatory and executive bodies both at national and regional level; ii) all health units at all levels of care, whether public or private; iii) all partners, such as non-governmental organizations, patients' associations, professional associations, scientific societies, academic and research institutions, and civil society, among others.

Another important and reinforced aspect of the GPSAP 2021-2030 was to highlight the importance of patient safety on the agendas of the countries' health policies, thus becoming the guiding principle for all national plans developed and to be developed in the patient safety area.

The analysis of the GPSAP 2021-2030, along with the several strategic plans from different countries, made it possible to identify a set of relevant common denominators in the design of the PNSD 2021-2026, among which the following stand out:

- Most of the documents analysed were produced in the last four years. This fact seems to be an unequivocal sign of the growing importance and centrality that the topic has been gaining in the health policy agendas of many countries;
- Key priority areas include safety culture, patient and family involvement, the importance of communication, leadership commitment, and the research development in this area;
- Some countries, such as England, Scotland, Spain, Australia and Sweden, in addition to cross cutting issues - such as safety culture and the need for patient and family involvement - focus their priorities on certain clinical specialties, in different stages of the life cycle or in different levels of care;
- The need to involve different stakeholders and to call for national and international partnerships for a better alignment and implementation of the defined actions;
- The concern to identify those responsible for the actions to be developed and to define targets and indicators to measure the level of execution and success of the defined plan or strategy.

2. National Plan for Patient Safety 2021-2026

2.1 Construction Methodology

Under the coordination of the DQS, the creation of the PNSD 2021-2026 began in September 2020, in a partnership with the National School of Public Health-NOVA (ENSP-NOVA), under the Cooperation Protocol between the DGS and ENSP-NOVA. In February 2021, the Advisory Working Group (AWG) was formed, aiming to support and monitor the preparation of the PNSD 2021-2026 proposal. The group included professionals from various areas of expertise, from quality in health and patient safety, academia, research and practice in the PHC units, in hospitals and in continuous and integrated care.

The PNSD 2021-2026 is based on a conceptual model based on a rigorous methodological design, and was based on a participatory and inclusive process, using different sources and techniques for collecting the information and analysis, in particular:

a) Literature review

b) Consulting process

   i. Questionnaire

   ii. Semi-structured interviews

   iii. Advisory Working Group

c) Triangulation

The ENSP-NOVA carried out the literature review and the listening process and published the methodology and proposals for the PNSD 2021-2026[3]. The triangulation technique was carried out by the DQS, which integrated the literature review and listening process. The PNSD 2015-2020 results evaluation were performed by ESEL and APDH.

a) Literature review

A systematic selection, analysis and collection of national and international strategic documents and guidelines, as well as of the available scientific articles, was carried out. Of these, the following strategic documents can be highlighted:

- WHO Global Patient Safety Action Plan 2021-2030 (GPSAP).
- Strategic plans from Switzerland, Spain, England and Wales, Ireland, Scotland, Finland and Australia, among others.
- National Health Plan and Health Programmes, in particular the DGS's National Programme on Prevention and Control of Infection and Antimicrobial Resistance.

b) Consulting Process

During the consulting process, professionals working in the quality and safety areas and national and internationally recognised experts were heard. This consultation was based on the application of a questionnaire and semi-structured interviews, accompanied by the Advisory Working Group.

i. Questionnaire

The questionnaire prepared by ENSP-NOVA, and validated by DQS, was available online, and included 90 questions (related to the PNSD 2015-2020 and the articulation between local, regional and national levels; strategic objectives and actions to be implemented under the PNSD 2015-2020; monitoring/follow-up of the actions and targets related to the strategic objectives; priorities for the PNSD 2021-2026).

The questionnaire was applied to: members of the CQS in hospitals, Hospital Centres, ULS and ACES; members of the Pharmacy and Therapeutics Commissions; members of the Local Coordination Groups of PPCIRA (GLC-PPCIRA);

3 Sousa P; Paiva S.G.; Lobão M.J. Van-Innis A. L.; Pereira C.; Fonseca V. Contributions to the Portuguese Plan for Patient Safety 2021-2026: A Robust Methodology on the Mixed. Method Approach. Port. J. Public Health. 2021; 39:275-192.

members of the Quality in Health and Patient Safety/ Risk Management Offices/Departments and the NOTIFICA Local Managers.

The online questionnaire was developed on the SurveyMonkey® platform and was applied from 25 March to 16 April 2021, with a total of 338 responses received and analysed.

ii. Semi-structured interviews

The semi-structured interviews, with a script developed for this purpose, included 9 questions. They were applied to: leaders of institutions under direct and indirect administration of the Ministry of Health and with relevance and interest in the patient safety area; persons/experts responsible for regional institutions at the Ministry of Health; national experts and academics and those responsible for the development of strategic plans at international level.

The questions addressed the positive aspects and difficulties experienced in the implementation of the PNSD 2015-2020, and more specific aspects, such as the objectives/actions/indicators and targets set, seeking to find principles and objectives for the PNSD 2021-2026.

The interviews, totalling 17, were conducted via videoconference between 10 May and 19 June 2021.

iii. *Focus Group*

From the AWG more restricted and specific working groups were formed, whose contributions, through participation in the Focus Group sessions, were of the greatest relevance to the process of drafting the proposal for targets, actions and indicators for the PNSD 2021-2026.

c) Triangulation

In order to reduce the possible biases and limitations of the different methods selected for collecting the information, it was decided to apply the «triangulation» technique. This technique results from the combination of different methodological perspectives when studying the same phenomenon, referring to the use of different methods in a study, aiming to cancel the intrinsic errors in each of them. For the design of the PNSD 2021-2026, different methodologies were used to collect information and was proposed to discuss the results according with two forms of triangulation: data (use of multiple sources of information) and methodological (use of multiple methods to study a single problem). The results analysis and interpretation according to the collection methods applied, constituted the scientific basis, allowing the DQS to identify the pillars, objectives, actions and targets that would incorporate the PNSD 2021-2026.

The design of the PNSD 2021-2026 also took into consideration the recommendations from the United Nations sustainable development objectives, specifically those in its third objective. More recently, included also the WHO's GPSAP 2021-2030, which reinforced the need to highlight the importance of patient safety on the health policy agenda, intending to become the guiding principle for all national plans, developed and to be developed in this area.

2.2. PNSD 2021-2026: Continuity and Innovation

The Health Basic Law, approved by Law No. 95/2019, of 4 September, in its Basis 1, on the right to the protection of health - where patient safety is one of its fundamental dimensions or components - reinforces the role of the State as its promoter and guarantor, through the SNS, the ARS and other central, regional and local public institutions. In its Basis 2, the Law also determines that, among others, people have the right to timely access to appropriate health care for their situation and in a clinically acceptable time, in a dignified manner, according to the best scientific evidence available and following good quality and safety practices in health. The SNS, in its actions must also be guided by these principles, one of them being quality, carried out in a humanised way, with technical accuracy and attention to the individuality of the person, as established in Basis 20. It is therefore important to give due and current relevance to quality and safety in health, in the health system, in particular in the SNS. Thus, and with the purpose of consolidating and promoting safety in health care provision, the PNSD 2021-2026 was developed, being both a continuity and an innovative plan:

4 Tashakkori, A., e C. Teddlie (1998), Mixed methodology. Combining qualitative and quantitative approaches (Applied Social Research Methods Series, vol. 46), Londres, Sage.

- Innovative, not only in some themes that have gained increasing relevance in the health care provision (such as at home care and telehealth), but also because its configuration is different. Now based on five pillars that are subdivided into numerous strategic objectives. This structure is materialised through dynamic actions and goals, to allow monitoring and updating according to the needs identified throughout its implementation. The choice for a dynamic plan allows, through continuous monitoring, the (re)definition of new actions and targets, which may prove to be necessary when faced with realities justifying it (for example, the COVID-19 pandemic proved the importance of versatility and promptness of the health responses).

- Continuity, because the evaluation of the PNSD 2015-2020 has shown that issues such as safe communication and incident reporting, among others, still lack the implementation of actions, within the strategic objectives and the (re)definition of the respective targets.

The PNSD 2021-2026 **aims to consolidate and promote safety in the provision of health care** in the health system, and particularly in the SNS, including in contexts specific to the current health systems, such as at home care and telehealth. Without neglecting the principles that underpin the patient safety area, as the safety culture, communication and continuous implementation of safe practices in increasingly complex environments. This Plan is a support tool for senior managers, middle managers, CQS collaborators, patient safety managers and health professionals thus requiring an active involvement from the governance, coordination and operationalization responsibilities at the different levels of care, in order to increase the safety of health care delivery, keeping in mind the focus on the patient and the caregivers.

The Plan is structured in five pillars supporting fourteen strategic objectives. The pillars establish a benchmark for consolidation and evolution of patient safety, integrating strategic objectives, whose targets are achieved through the active implementation of the actions defined in this technical document.

2.3. Pillars and Actions

In this chapter, each pillar is contextualized and the strategic objectives and respective actions are presented and those responsible for their implementation. Whenever possible, this technical document uses example activities for each action, making the document a facilitating tool for the implementation and achievement of the objectives and targets of the PNSD 2021-2026, both in 2023 and 2026, in accordance with Order No. 9390/2021, of 24 September.

The mid-term evaluation in 2024 allows the level of implementation and compliance with the targets and indicators to be verified and updated, if necessary, in an evolutionary and improving perspective, which the PNSD 2021-2026 introduced as a novelty.

2.3.1. Pillar 1. Safety Culture

Patient safety is a public health priority and a critical component of quality healthcare and depends on the commitment of the leadership, transparency, communication, learning from mistakes, improving the quality of healthcare, a no blame culture and accountability.

Safety culture is fundamental to reduce incidents in the health care delivery, as well as to provide a safe environment for health professionals and, consequently, for patients. Currently, the inclusion of patients, family members and caregivers in the safety culture is increasingly relevant, considering health literacy as one of the sustaining foundations for this pillar.

The WHO and the Council of the European Union have highlighted these findings and recommended the Member States to include the safety culture in their national policies.

Achieving a safety culture requires transformational change, in an environment that promotes systematic and continuous data collection and a focus on respect and transparency.

It is therefore essential to build trust, establish principles of accountability and make it easier for the professionals to identify unsafe situations and environments.

The promotion of a safety culture, aligned with a process of continuous improvement, through communication, training and awareness-raising, should not only be a choice, but an imperative for all professionals, the senior management and the leadership of the healthcare institutions, and the responsibility of all.

Pilar 1. Safety Culture

Strategic Objective 1.1

Promote the training of health care professionals within the scope of patient safety.

ACTIONS	RESPONSIBLE FOR
a) Develop courses, preferably online, on patient safety and on reporting patient safety incidents, as well as in the fields of promoting or reinforcing the involvement of patients, families and caregivers: **SAMPLE ACTIVITY** ◆ Design and dissemination of online training actions in the area of patient safety, patient safety incident reporting, and in the promotion or strengthening the involvement of the patient, family and caregiver	• Senior management and leadership in the health care institutions within the health system
b) Implement an annual training plan, within the scope of patient safety, for health professionals at health care units. **SAMPLE ACTIVITY** ◆ Design, disseminate and implement annual training sessions for health professionals in the health care units, on patient safety, on the reporting of patient safety incidents and on the promotion or reinforcement of patient, family and caregiver involvement	• Senior management and leadership in the health care institutions within the health system

Pilar 1. Safety Culture

Strategic Objective 1.2

Evaluate the Safety Culture.

ACTIONS	RESPONSIBLE FOR
a) Update the Safety Culture Assessment Model. **SAMPLE ACTIVITIES** ◆ Review of the ACS questionnaire; ◆ Implement the ACS questionnaire; ◆ Monitor the ACS questionnaire for PHC and Hospitals; ◆ Design improvement actions following the results from the ACS.	• DGS, CQS, partnership entities and senior management and leadership in the health care institutions • Healthcare institutions within the health system, through the CQS and health care providers • Health care institutions

Pilar 1. Safety Culture

Strategic Objective 1.3

Increase literacy and the participation of patients, families, caregivers and society in the safe health care.

ACTIONS	RESPONSIBLE FOR
a) Develop and implement an awareness plan aimed at patients, families and caregivers, on the importance of safety in health care, articulated with the Health Literacy Action Plan; **SAMPLE ACTIVITY** ◆ Design and execution of awareness-raising actions aimed at patients, families and caregivers (patients' associations, volunteers' associations ...), on the relevance of safety in the health care, articulating with the Health Literacy Action Plan.	• Professionals and senior management and leadership in the health care institutions within the health care system
b) Involve patients, families, caregivers and society in the actions of the PNSD 2021-2026; **SAMPLE ACTIVITIES** ◆ Development of awareness-raising actions aimed at citizens (patients, family members and caregivers), regarding the prevention and control of infections (PPCIRA), for example, through the implementation of the e-Bug Project and the intervention project in the continuous care units for the reduction of the urinary tract infection (UTI); ◆ Develop other awareness raising actions aimed at the citizen in the patient safety context.	• Professionals and senior management and leadership in the health care institutions within the health system
c) Carry out communication campaigns and awareness raising actions regarding patient safety. **SAMPLE ACTIVITY** ◆ Design, plan and carryout communication campaigns aimed at the public (young people, adults, the elderly, etc.) on the relevance of safety in healthcare.	• DGS

2.3.2. Pillar 2. Leadership and Governance

Leadership in the health institutions is a determining factor for the best governance. By prioritising, developing and creating the conditions to ensure an institutional culture focused on patient safety the leadership and managers of health care institutions take the institution to where patients/citizens, their families and health professionals feel confident and open to discuss and anticipate the weaknesses of the system, but also to respond transparently to the complex challenges in the health care delivery.

The WHO, in its GPSAP 2021-2030, integrate the concepts of leadership and governance within patient safety as a way of creating a safe and enabling environment.

According to the WHO, leadership commitment involves several requirements, such as: transparency (from patients and health professionals, whether in sharing information or reducing a hierarchical approach, in a cross-cutting perspective), open and respectful communication, development of a culture enabling learning from mistakes and best practices, teamwork, willingness to learn, valuing and supporting health professionals, and a judicious balance between the no-blame policy and accountability. Therefore, these requirements become indispensable to the culture of safety and come from leadership, bearing in mind that the patient should be at the centre of care and the system.

This process requires strong leadership at all levels, from the Ministry of Health (MoH), health institutions, partners and all teams involved in the delivery of care. The WHO also recommends the implementation of interconnected strategies, including improved governance and accountability, to enable the reorganisation of the care model, the coordination of services, within and between sectors, and the creation of a facilitating environment.

Also according to the WHO and embodied in the Global Action Plan, the actions necessary for its success must be transformational in nature.

Leadership and governance are crosscutting concepts to all institutions, to ensure that these are reflected in the PNSD 2021-2026, thus encouraging their participation, the implementation and operationalization. It is essential to maintain the governance structures that have actively participated in the promotion of quality in health and patient safety since the beginning, at national (MoH, DGS and other central institutions of the MoH), regional (ARS) and local (CQS and top management of the institutions) levels.

BACK TO INDEX

Pillar 2. Leadership and Governance

Strategic Objective 2.1

Ensure the involvement of senior management and leadership of the institutions in the implementation of PNSD 2021-2026.

ACTIONS	RESPONSIBLE FOR
a) Develop the PNSD 2021-2026 performance indicators index, and their integration in the terms of reference of the SNS health care contracting; **SAMPLE ACTIVITY** ◆ The organisation of meetings for the definition and inclusion of contracting indicators in the programme contracts of the health institutions.	• DGS and ACSS
b) Implement an annual training plan on patient safety, aimed at health professionals from the health care units; **SAMPLE ACTIVITY** ◆ The healthcare institutions shall have and implement annual patient safety training plan, aimed at various categories of professionals.	• ARS, CQS, senior management and leadership in the health care institutions
c) Define protected time for the health professionals involved in the implementation of the PNSD 2021-2026 and in other patient safety activities. **SAMPLE ACTIVITY** ◆ Health care institutions must define actions that include protected time for the implementation of this Plan and include them in their respective Activity Plans. The ARS must ensure that the institutions have allocated protected time to the health professionals for the implementation of the PNSD 20212026.	• ARS, senior management and leadership in the health care institutions

Pillar 2. Leadership and Governance

Strategic Objective 2.2

Consolidate the articulation between the patient safety governance structures, at national, regional and local levels.

ACTIONS	RESPONSIBLE FOR
a) Update the governance model of the CQS	• DGS, ARS and CQS

BACK TO INDEX

2.3.3. Pillar 3. Communication

Effective and efficient communication in a health care institution is one of the main pillars for the promotion of safe care. Different studies show that effective communication between health professionals, patients and their families is essential for the prevention of adverse events.

One of the areas highlighted by the WHO was the "Communication between professionals during patient handoffs/transitions of care" published in the document Patient Safety Solutions: Solution 3 "Communication During Patient Handoffs". This document describes the complexity of the patient's pathway along the continuum of care, because the patient may receive care from different healthcare professionals, in different settings and at different levels of care. The WHO also warns that the change of professionals and teams between shifts, as well as the patient handoffs between diagnosis and therapy areas, increase the risks of safety incidents resulting from break downs in communication and transfer of information.

Consequently, communication throughout the patient's pathway is vital for the quality and safety of care, particularly during patient handoffs, transfer of responsibility or passing information between health professionals or from caregivers to the patient and family.

The "Communication" pillar aims at developing and implementing strategies and tools, using digital media in the promotion of good clinical and management practices. One challenge is the consolidation of the interoperability of digital media and systems, in order to integrate patients' clinical information, and for this to be accessible to the health professionals in a swift and timely manner.

The implementation of guidelines on communication during patient handoffs, the adoption of best practices by professionals and the effective involvement of the patient/family/caregiver in the whole process of care require the development of robust and consistent training programmes covering all healthcare professionals and awareness-raising actions and campaigns on safe communication for healthcare professionals and citizens. Internal audits in this area are also an essential tool for monitoring the process of continuous improvement.

Pillar 3. Communication

Strategic Objective 3.1

Optimise intra and inter-institutional communication.

ACTIONS	RESPONSIBLE FOR
a) Implement the use of digital media for the dissemination and use of guidelines and other tools of good clinical and management practices; **SAMPLE ACTIVITY** ◆ Develop accessible information systems, enabling the integration of tools that support decision-making in the electronic health records.	• DGS, SPMS and senior management and leadership in the health care institutions within the health system
b) Consolidate the interoperability of the digital media for the integration of patients' clinical information. **SAMPLE ACTIVITY** ◆ Integration of the electronic health records information system modules at all levels of care.	• DGS, SPMS, ACSS

Pillar 3. Communication

Strategic Objective 3.2

Improve communication and safety in the transition of care.

ACTIONS	RESPONSIBLE FOR
a) Update the guidelines on communication in the transition of care;	• DGS, SPMS
b) Develop and implement communication tools, for a safe transition and transfer during the provision of care, between health professionals and the different levels of care; **SAMPLE ACTIVITIES** ◆ Situation assessment and diagnosis regarding the communication techniques and tools used in the institutions, through the application of a questionnaire. ◆ Performing internal audits of the communication process during the transition of care.	• Health care institutions of the health system
c) Develop specific training programmes aimed at health professionals on transfer of information during the transition of care process. **SAMPLE ACTIVITIES** ◆ Define the safe communication training contents; ◆ Carrying out multi-professional training actions, including leaderships, on safe communication	• Health professionals and senior management and leadership in the health care institutions

Pillar 3. Communication

Strategic Objective 3.3

Adjust the communication of clinical information to patients, families and caregivers.

ACTIONS	RESPONSIBLE FOR
a) Update the informed, clarified and freely given consent and promote its adequate use during the clinical communication process to the patient; **SAMPLE ACTIVITY** ◆ Update the Guideline No. 015/2013 "Written, informed, clarified and freely given consent" to be available online. Development and availability of tools for the patient on the procedures/treatments to be performed and associated risks.	• DGS and SPMS
b) Monitor the proper use of the informed, clarified and freely given consent in the clinical communication. **SAMPLE ACTIVITIES** ◆ Promote awareness raising actions for professionals and patients on safe communication in healthcare; ◆ Provide information to citizens on informed, clarified and freely given consent in clinical communication; ◆ Conduct internal audits on the use of informed, clarified and freely given consent in clinical communication.	• Health professionals and senior management and leadership in the health care institutions within the health system

2.3.4. Pillar 4. Prevention and management of patient safety incidents

One of the key points that the WHO's GPSAP 2021-2030 addresses is the no blame patient incident reporting by health professionals, thus enabling learning and avoiding the repetition of errors.

Pillar 4 "Prevention and management of patient safety incidents" of the PNSD 2021-2026 reflects this recommendation by the WHO.

The PNSD 2015-2020 reflected the concern to address the issue of safety incident reporting.The WHO and the European Commission have recommended Member States to develop safety incident reporting systems, independent from complaint and/or disciplinary systems and to promote learning from error and the consequent implementation of improvement actions. These organisations also recommend ensuring the confidentiality of the person reporting and the anonymity of the information reported.

The NOTIFICA is a reporting system that aims to improve patient safety by allowing the management of incidents occurring in the health system. Reporting systems are an important tool in the pursuit of patient safety. These are voluntary, anonymous, confidential and non-punitive systems. These crucial characteristics - being an anonymous, confidential and non-punitive system - may be faced with obstacles that require a reflection on the legal framework of these systems.

The PNSD 2021-2026 defines the strategic objective "to increase the transparency reporting culture of incidents in the NOTIFICA system. This objective should be accomplished through several actions: encourage the reporting of safety incidents during the provision of health care, through training and availability of tools to facilitate the reporting; integrate the reporting of safety incidents in the NOTIFICA in the contracting targets of the health care institutions; and creation of a legal framework for confidentiality and protection of the person reporting.

The NOTIFICA system is undergoing a changing process regarding patient safety reporting in order to provide a better response to the needs of the person reporting, whether if it is the citizen or the health professional, but also to the person analysing and implementing the improvement measures - the patient safety managers. This system should also allow the monitoring of patient safety related incidents, supporting the decision-making at local, regional and national level, with special focus on improving the quality in health.

Pillar 4. Prevention and management of patient safety incidents

Strategic Objective 4.1

Increase the culture and transparency when reporting patient safety incidents in the NOTIFICA system.

ACTIONS	RESPONSIBLE FOR
a) Encourage the reporting of patient safety incidents associated with pharmacovigilance and haemovigilance in the NOTIFICA system, through training sessions and the provision of facilitating tools; **SAMPLE ACTIVITIES** ◆ Develop multi-professional training actions in health institutions on the importance of reporting patient safety related incidents as a (non-punitive) strategy to learn from error and prevent future incidents; ◆ Develop training sessions for the professionals about patient safety, risk management and incident analysis tools; ◆ Raise awareness among health professionals and citizens on the importance of reporting safety incidents; ◆ Raise awareness among health professionals and citizens on the importance of reporting for the safety culture through workshops, organising events to celebrate the World Patient Safety Day, posters (placed in strategic places in the health institutions), information available on the DGS/ SNS website, etc.; ◆ Disseminate throughout the health institutions, the safe practices to be implemented, national and international guidelines, recommendations and alerts related to patient safety, using the institutional intranet, local newsletter, NOTIFICA newsletter, etc.; ◆ Present the NOTIFICA system to health professionals and citizens, its purpose and the different steps of the reporting process, including the feedback to reports; ◆ Promote moments to share experiences on the importance of reporting for the safety culture, incident management and improvement measures adopted in health institutions, covering the different levels of care and contexts; ◆ Organise and carry out trainings sessions on reporting for the health professionals.	• DGS, INFARMED, SPMS, ARS, IPST, CQS, health professionals and senior management and leadership in the health care institutions.

Pillar 4. Prevention and management of patient safety incidents

Strategic Objective 4.1 (continued)

Increase the culture and transparency when reporting patient safety incidents in the NOTIFICA system.

ACTIONS	RESPONSIBLE FOR
b) Include the reporting of safety incidents in the NOTIFICA system in the contracting targets of the healthcare institutions; **SAMPLE ACTIVITY** ◆ Inclusion and promotion of the NOTIFICA reporting system in the contracting targets.	• DGS, ACSS, SPMS, health care institutions within the health care system
c) Publish, disseminate, and implement the legal framework for the confidentiality and protection of the person reporting. **SAMPLE ACTIVITY** ◆ Prepare and present a legal framework to ensure confidentiality and protection of the person reporting.	• DGS, ARS and partner entities.

Pillar 4. Prevention and management of patient safety incidents

Strategic Objective 4.2

Promote the follow up and assessment of the patient safety incidents in the NOTIFICA system.

ACTIONS	RESPONSIBLE FOR
a) Optimise the NOTIFICA as a national platform for reporting patient safety incidents; **SAMPLE ACTIVITIES** ◆ Develop the NOTIFICA, making it more user-friendly; ◆ Disseminate the new NOTIFICA to professionals and citizens, through digital systems, DGS/SNS website, institutional intranet, posters.	• DGS, SPMS, ARS, CQS
b) Develop a module for auditing safe practices in the NOTIFICA system; **SAMPLE ACTIVITIES** ◆ Creation of the safe practices audit module in the NOTIFICA; ◆ Develop the procedure for the audit module application in the different levels and contexts of care, including at home care and telehealth.	• DGS, SPMS, ARS, CQS
c) Implement tools and procedures for monitoring and providing feedback on safety incidents to the professionals and citizens. **SAMPLE ACTIVITIES** ◆ Develop tools for incident monitoring and feedback at local and national level; ◆ Develop training sessions on tools and procedures for monitoring safety incidents for health professionals dedicated to patient safety; ◆ Optimize the functionalities of the NOTIFICA for patient safety managers regarding the analysis of incidents, management of new reports (e.g.: alert system with updated information, available in graphic form and by type of incident); ◆ Prepare the procedure for the report feedback to the person reporting, according to the provisions of the legal framework for the confidentiality and protection of the person making the report.	• DGS, SPMS, ARS, CQS and NOTIFICA managers

2.3.5. Pillar 5. Safe Practices in Safe Environments

In the GPSAP 2021-2030, the WHO defines patient safety as "a framework of organised activities that creates cultures, processes, procedures, behaviours, technologies and environments in health care that consistently and sustainably lower risks, reduce the occurrence of avoidable harm, make errors less likely and reduce the impact of harm when it does occur".

Ensuring safe environments for the timely delivery of safe care requires an effort by all stakeholders to ensure the necessary physical, technical and operational conditions, relying on the managers and leadership of the health institutions.

Several aspects influence the development and maintenance of safe practices in safe environments, such as: the report of incidents and adverse events, in a learning and safety improvement approach; the creation of an environment where risks can be openly discussed, solutions proposed and non-punitive response mechanisms to errors and a transparent and fair culture exist.

The COVID-19 pandemic highlighted the numerous challenges to patient safety and the safety of health professionals in the face of a public health emergency of this magnitude, corroborating the priority that the safety of health systems has in health care delivery.

Within these areas, the DGS, through the DQS, has been developing and issuing guidelines, with the purpose of improving the quality and safety of health care delivery. Within the scope of safe practices, the PNSD 2015-2020 also implemented the internal audits to promote the continuous improvement in terms of structures, practices and results; and verifying the application of strategies and procedures to increase patient safety. In these areas, continuity is given to the work initiated and the need for professionals and institutions to have access to the results is reinforced.

In compliance with Decision No. 2119/98/EC of the European Parliament and of the Council of 24 September 1998, Portugal takes part in the numerous programmes for epidemiological surveillance (ES) of healthcare-associated infections, antimicrobial consumption and antimicrobial resistance (AMR).

According to the OECD Report (2019) Antimicrobial Resistance Tackling the Burden in the European Union, AMR is a complex issue on a global scale, with potentially dramatic consequences for health and the economy.

In 2016, the WHO released the core components that should guide national and local infection prevention and control programmes through the Guidelines on core components of infection prevention and control programmes at the national and acute health care facility level.

Portugal has a priority health programme, PPCIRA (created by Order 2902/2013 of 22 February), which is dedicated to the prevention and control of HAIs, the promotion of the good use of antimicrobials and the reduction of AMR.

The fundamental activities of PPCIRA are: epidemiological surveillance of HAIs, antimicrobial consumption and antimicrobial resistance; promoting adherence and compliance with basic measures for infection control and for modes of transmission; the promoting and implementation of bundles of healthcare for the prevention of healthcare-associated infections; promoting and developing programmes to support antimicrobial stewardship; elaboration of guidelines and capacitating educational training activities of professionals; creation and development of behavioural training methodologies, in particular the commented feedback of data; facilitating the quality improvement interventions and the development of activities promoting citizen's literacy on this topic, in particular the PORCAUSA Campaign (Portuguese Campaign For The Safe Use Of Antibiotics).

In recent years, there has been an improvement in good hand hygiene practices and in the results of audits on basic infection control precautions, a reduction in the consumption of carbapenems in hospitals and of quinolones in outpatient settings, and a reduction in the resistance rate of most monitored microorganisms. In the epidemiological surveillance of HAI's incidence, there was a reduction in the overall incidence of surgical site

infection, hospital-acquired bloodstream infection, particularly central venous catheter-related, endotracheal tube-associated pneumonia and tracheobronchitis in adult intensive care units and Clostridioides difficile infection.

In response to new health needs, and in alignment with this Pillar, telehealth emerges as an innovation, which, in the context of the COVID-19 pandemic, has been the object of great attention and concern, and has therefore been contemplated in this Plan, in order to guarantee good practices in terms of patient safety.

The introduction and development of telehealth tools is already a national reality in some contexts. However, its expansion to the different levels of care is still a challenge, as the implementation of telehealth models will only make sense if it adds value to people's health, thus ensuring the principles of humanization, quality and safe care.

The introduction of innovative mechanisms should contribute to the model of personalised, person centred care, aligned with the demographic changes and biotechnological innovation, people's expectations and the empowerment of services to demonstrate results, based on the principles of quality in health.

In this context, in the scope of health innovation, for the development and implementation of successful teleconsultation and tele monitoring projects, the following assumptions may have to be taken into account:

- More humanisation in health care delivery;
- Integration of the best scientific evidence in a swift and timely manner;
- Clear and unambiguous definition of care pathways to facilitate citizens' navigation through the different levels of care;
- Maximum safety in the provision of health care, including among others, the elaboration of procedures, registries, risk assessment and secure monitoring of data.

The integration of the concepts and guidelines for increasing Quality and Safety in Health such as telehealth models, is conditioned by external variables to the technological development process, which should be interpreted as challenges for the implementation of this tool, these being:

- the level of the citizens' digital literacy;
- the articulation of IT professionals with health professionals;
- the creation of qualification programmes for health professionals in this field;
- the definition of an individual care plan together with the patient;
- the promotion of the home as a level of care;
- the definition of criteria to ensure the quality of the care provided and supported by the tele monitoring;
- no replacement of personal interaction between health professional and patient and caregiver/family;
- the definition of safe processes;
- the protection of personal data.

Pillar 5. Safe Practices in Safe Environments

Strategic Objective 5.1

Implement and consolidate safe practices in a healthcare environment.

ACTIONS	RESPONSIBLE FOR
a) Promote the use of digital tools for safe practices concerning safe surgery, safe childbirth, falls, pressure ulcers, patient misidentification, medication safety and medication reconciliation; **SAMPLE ACTIVITY** ◆ Implement standardise verification practices within the safe practices, using digital tools.	• DGS, SPMS, health care institutions and senior management and leadership
b) Standardise the use of tools for monitoring the risk of safety incidents in the provision of care at different levels of care, including at home. **SAMPLE ACTIVITY** ◆ Define monitoring criteria to be adopted and implemented by health units and institutions.	• DGS, SPMS, health care institutions and senior management and leadership

Pillar 5. Safe Practices in Safe Environments

Strategic Objective 5.2

Monitor the implementation of safe practices.

ACTIONS	RESPONSIBLE FOR
a) Update the guidelines in the patient safety area;	• DGS
b) Have an annual audit regarding safe practices related to safe surgery, safe childbirth, falls, pressure ulcers, patient misidentification and medication safety; **SAMPLE ACTIVITIES** ◆ Production of instruments (e.g. checklist) and support materials for internal audits based on the DGS' guidelines; ◆ Organise and conduct training sessions for auditing professionals.	• Health care institutions and senior management and leadership
c) Develop and implement the Contingency Plans for Public Health Emergencies, with special attention to the area of patient safety. **SAMPLE ACTIVITIES** ◆ Publication of Contingency Plans with a common basis and with possible updates to the different levels and types of care, when justified; ◆ Update the Contingency Plans for Public Health Emergencies, with the respective adaptation to the national and institutional context.	• DGS and Public Health Departments at the ARS, senior management and leadership and health care institutions

Pillar 5. Safe Practices in Safe Environments

Strategic Objective 5.3

Reduce healthcare-associated infections (HAIs) and antimicrobial resistance (AMR).

ACTIONS	RESPONSIBLE FOR
a) Promote the adherence of health institutions to the multimodal strategy on basic precautions for infection control, as recommended by PPCIRA; **SAMPLE ACTIVITIES** ◆ Involve the top and middle management of the institutions, increasing commitment to the prevention and control of HAIs, good use of antimicrobials and prevent the emergence of AMR; ◆ Implement interventions to ensure that health institutions adhere to the multimodal strategy on basic precautions for infection control, as recommended by PPCIRA; ◆ Implement interventions that ensure the participation of the Units in the National Network for Integrated Continuous Care in the ITUCCI Project, to reduce device associated urinary tract infection (https://www.dgs.pt/programa-de-prevencao-e-controlo-de-infecoes-e-de-resistencia-aos-antimicrobianos/projetos-europeus/par-foundation.aspx).	• Senior management and leadership at health care institutions and national, regional and local PPCIRA structures
b) Implement the PPCIRA epidemiological surveillance programmes for HAIs; **SAMPLE ACTIVITIES** ◆ Develop interventions that guarantee the implementation of epidemiological surveillance programmes, as recommended by PPCIRA; ◆ Develop actions to ensure the integrated vision and management of epidemiological surveillance programmes for HAIs, antimicrobial consumption and AMR; ◆ Disseminate the results of epidemiological surveillance to the health professionals and provide frequent and if possible, continuous feedback, supporting the development of quality improvement interventions.	• Health care institutions and their respective senior management and leadership

Pillar 5. Safe Practices in Safe Environments

Strategic Objective 5.3 (continued)

Reduce healthcare-associated associated infections (HAIs) and antimicrobial resistance (AMR).

ACTIONS	RESPONSIBLE FOR
c) Uphold and enable the services to implement and monitor the HAIs prevention bundles; **SAMPLE ACTIVITIES** ◆ Implement and monitor the HAI prevention bundles, according to the respective Clinical Guidance Guidelines published by the DGS, in order to sustain and support the services in this area; ◆ Revise the guidelines of the HAI prevention bundles, and reinforce their pedagogy.	• Senior management and leadership at health care institutions and national, regional and local PPCIRA structures
d) Promote the implementation of the Antimicrobial Stewardship Programs, using and developing restrictive and training methodologies, both educational and behavioural; **SAMPLE ACTIVITIES** ◆ Develop interventions promoting the implementation of the Antimicrobial Stewardship Programs in all Health Units, using and developing empowering methodologies, both educational and behavioural.	• Senior management and leadership at health care institutions and national, regional and local PPCIRA structures
e) Ensure the allocation of protected time to professionals involved in the prevention, control and monitoring of HAIs and in the operationalization of the Antimicrobial Stewardship Programs (ASP) in health institutions, in accordance with Order no. 15423/2013, of 26 November; **SAMPLE ACTIVITIES** ◆ Allocation of protected time to professionals involved in the prevention, control and monitoring of HAIs and the operationalization of the ASP in health institutions (with the minimum reference being Order No. 15423/2013 of 26 November).	• Senior and middle management and leadership at health care institutions and national, regional and local PPCIRA structures

Pillar 5. Safe Practices in Safe Environments

Strategic Objective 5.3 (continued)

Reduce healthcare-associated associated infections (HAIs) and antimicrobial resistance (AMR).

ACTIONS	RESPONSIBLE FOR
f) Share with health professionals the results of the outcome and process indicators defined for the HAIs, Antimicrobial Consumption (AMC) and AMR areas, and their relations with the implementation of quality improvement interventions. **SAMPLE ACTIVITIES** ◆ Involve the health professionals in clinical contexts in developing improvement actions adequate to the actual reality of the services and that can be translated into improving the outcome indicators; ◆ Consolidate the effective cooperation work between the Administration, CQS, Local Coordination Groups-PPCIRA, Clinical Services and Epidemiology Centres/Services at Health Units; ◆ Develop the STOP-IH 2.0 project to expand the good results obtained in reducing the incidence of 4 types of hospital-acquired infections, to 12 other hospital units	• Senior and middle management of health institutions and national, regional and local PPCIRA structures

Strategic Objective 5.4

Promoting safe telehealth.

ACTIONS	RESPONSIBLE FOR
a) Elaborate and implement a guideline on telehealth, ensuring the best practices in the patient safety area.	• DGS and SPMS

2.3.6. PNSD 2021-2026 Main Actions

Safety Culture

- Online courses (health professionals);
- Training plans (health professionals);
- Review the Safety Culture Assessment Questionnaire;
- Awareness raising actions (patient, families and caregivers);
- Communication campaigns (patient, families and caregivers).

Leadership and Governance

- Index of performance indicators for the contracting agreements;
- Annual training plan;
- Definition of protected time (professionals involved in patient safety, including PPCIRA);
- Revision and publication of the CQS legal framework.

Communication

- Update the guidelines on communication in the transition of care;
- Communication tools;
- Specific training programmes;
- Guideline on informed, clarified and freely given consent.

Prevention and management of safety incidents

- Integrate the NOTIFICA safety incident reporting in the contracting targets;
- Publish the legal framework for the confidentiality and protection of the person reporting;
- Optimise the NOTIFICA system;
- Develop the NOTIFICA audit module for safe practices;
- Promote IT and integrated epidemiological surveillance systems.

Safe Practices in Safe Environments

- Update the guidelines within the patient safety area, including the PPCIRA;
- Develop an Educational Plan within the PPCIRA scope;
- Reformulate and implement the PPCIRA Quality Index in hospitals, PHC and RNCCI;
- Publish the Guideline on telehealth.

2.4. Monitoring and Evaluation of the PNSD 2021-2026

This chapter "Monitoring and Evaluation of the PNSD 2021-2026" aims to explain the monitoring and evaluation of the Plan.

The results analysis will not only contribute to the continuous improvement of the safe and quality healthcare delivery but will also support informed and strategic decision-making at local, regional and national levels.

As previously mentioned, this Plan intends to be dynamic, in line with the needs and challenges that may arise in the patient safety area. Throughout its duration period, it may be necessary to adapt to new needs and challenges.

Monitoring and Evaluation Committee

Under the provisions of subparagraph b), paragraph 2, of Order No. 9390/2021, of 24 September, which approves the PNSD 2021-2026, a Monitoring and Evaluation Committee for this Plan was created.

This Committee will incorporate elements of the DGS (DQS, PPCIRA, and Health Literacy Action Plan), SPMS, ACSS and INFARMED, as well as elements from different areas and levels of health care, and with regional and local representation.

The monitoring and evaluation of the PNSD 2021-2026 will have 3 stages to analyse the results and respective impact, considering the strategic objectives and respective targets:

- Gather data through an online form, to be filled in annually by the CQS in the health institutions or other entities. The form will be made available by the DGS;
- Analysis of the data, to be carried out by the DGS and the Monitoring and Evaluation Committee of the PNSD 20212026, with the possibility of resorting to partnerships;
- Publication of the national results by the DGS and their use to support strategic planning in quality in health.

It should also be noted that, according to Order No. 9390/2021, of 24 September, which approves the PNSD 2021-2026, it is planned:

- An intermediate evaluation on the PNSD 2021-2026 execution and the presentation of a report with the evaluation of the implementation process, by the DGS, by the end of the 1st semester of 2024;
- A final evaluation, through the presentation of a report on the implementation of the PNSD 2021-2026, by the DGS, until the end of the 1st semester after its respective duration.

2.4.1. Pillar 1. Safety Culture

Strategic Objective 1.1

Promote the training of health care professionals within the scope of patient safety.

ACTIONS

a) Develop courses, preferably online, on patient safety and on reporting patient safety incidents, as well as in the fields of promoting or reinforcing the involvement of patients, families and caregivers;

b) Implement an annual training plan, within the scope of patient safety, for health professionals at health care units.

GOAL 2026

Goal 1 - 95 % of healthcare institutions with annual multi-professional training plans in patient safety area.

INDICATOR

Goal 1

$$\frac{\text{No. of health care institutions with annual and multi-professional training plans on PS*}}{\text{Total No. of eligible health care institutions}} \times 100$$

*PS - Patient Safety

Source: numerator data known by each health institution, denominator data known by DGS (SNS health institutions).

BACK TO INDEX

2.4.1. Pillar 1. Safety Culture

Strategic Objective 1.2

Evaluate the Safety Culture (ACS).

ACTION

a) Update the Safety Culture Assessment Model.

GOAL 2023

Goal 2 - Full review of the safety culture assessment questionnaire, in conjunction with the CQS.

GOAL 2026

Goal 3 - 95% of health care units, with the Safety Culture Assessment questionnaire implemented.

INDICATORS

Goal 2

Full review of the safety culture assessment questionnaire in cooperation with the CQS.

Goal 3

$$\frac{\text{No. of health care units with the ACS* questionnaire implemented}}{\text{Total No. of eligible health care institutions}} \times 100$$

*ACS - Safety Culture Assessment

Source: numerator data known by each health institution, denominator data known by the DGS (SNS health institutions).

BACK TO INDEX

2.4.1. Pillar 1. Safety Culture

Strategic Objective 1.3

Increase literacy and the participation of patients, families, caregivers and society in the safe health care.

ACTIONS

a) Develop and implement an awareness plan aimed at patients, families and caregivers, on the importance of safety in health care, articulated with the Health Literacy Action Plan;

b) Involve patients, families, caregivers and society in the actions of the PNSD 2021-2026;

c) Carrying out communication campaigns and awareness-raising actions regarding patient safety.

GOALS 2026

Goal 4 - 90% of healthcare institutions with at least one annual awareness-raising action aimed at patients, families and caregivers.

Goal 5 - An annual nationwide patient safety communication campaign.

INDICATORS

Goal 4

$$\frac{\text{No. of healthcare institutions with at least 1 ARA* for patients, families and caregivers}}{\text{Total No. of eligible health care institutions}} \times 100$$

*ARA - Awareness Raising Action

Source: numerator data known by each health institution, denominator data known by DGS (SNS health institutions).

Goal 5

Conducting an annual nationwide patient safety communication campaign.

2.4.2. Pillar 2. Leadership and Governance

Strategic Objective 2.1

Ensure the involvement of senior management and leadership of the institutions in the implementation of PNSD 2021-2026.

ACTIONS

a) Develop the PNSD 2021-2026 performance indicators index, and their integration in the terms of reference of the SNS health care contracting;

b) Implement an annual training plan on patient safety, aimed at health professionals from the health care units;

c) Define protected time for the health professionals involved in the implementation of the PNSD 2021-2026 and in other patient safety activities.

GOALS 2026

Goal 6 - 70% of the hospital institutions with patient safety indicators in the contracting agreements.

Goal 7 - 100 % of Primary Health Care units with patient safety indicators in the contracting agreements.

INDICATORS

Goal 6

$$\frac{\text{No. of hospital institutions with PS* contracting indicators}}{\text{Total No. of eligible health care institutions}} \text{ X100}$$

*PS - Patient Safety

Source: numerator data known by each health institution, denominator data known by DGS (SNS health institutions).

Goal 7

$$\frac{\text{No. of PHC institutions with PS* contracting indicators}}{\text{Total No. of eligible health care institutions}} \text{ X100}$$

*PS - Patient Safety

Source: numerator data known by each health institution, denominator data known by the DGS (SNS health institutions).

2.4.2. Pillar 2. Leadership and Governance

Strategic Objective 2.2

Consolidate the articulation between the patient safety governance structures, at national, regional and local levels.

ACTION

a) Update the governance model of the CQS.

GOAL 2026

Goal 8 - Publication of the revised legal framework of the CQS.

INDICATOR

Publication of the revised legal framework of the CQS (Order No. 3635/2013, of 7 March), until 2023.

2.4.3. Pillar 3. Communication

Strategic Objective 3.1

Optimise intra and inter-institutional communication.

ACTIONS

a) Implement the use of digital media for the dissemination and use of guidelines and other tools of good clinical and management practices;

b) Consolidate the interoperability of the digital media for the integration of patients' clinical information.

GOAL 2023

Goal 9 - 95% of ACES with access to the hospital's discharge notes.

GOALS 2026

Goal 10 - 95% of services and/or institutions in the SNS with digital records of the discharge and transfer notes, through the Electronic Health Records, in accordance with Order no. 2784/2013, of 20 February; 100% of the ACES with access to all of the hospital's discharge notes;

Goal 11 - 100% of the ACES with access to all the hospital's discharge notes.

INDICATORS

Goal 9

$$\frac{\text{No. of ACES with access to hospital's discharge notes}}{\text{Total No. of eligible ACES}} \text{ X100}$$

Source: numerator data known by each ACES and ACSS (updated to the previous civil year), denominator data known by DGS (SNS health institutions).

Goal 10

$$\frac{\text{No. of hospital services in the SNS with ER* of discharge notes and transfer notes in the EHR**}}{\text{No. of hospital services of the eligible health institutions}} \text{ X100}$$

$$\frac{\text{No. of PHC units in the SNS with ER* of discharge notes and transfer notes in the EHR**}}{\text{No. of eligible PHC units}} \text{ X100}$$

* ER - Electronic Records

** EHR - Electronic Health Records

Source: numerator data known by each institution and ACSS (updated to the previous civil year), denominator data known by DGS (SNS health institutions).

Goal 11

$$\frac{\text{No. of ACES with access to all discharge notes from hospitals}}{\text{Total No. of eligible ACES}} \text{ X100}$$

Source: numerator data known by each ACES and ACSS (updated to the previous civil year), denominator data known by DGS (SNS health institutions).

2.4.3. Pillar 3. Communication

Strategic Objective 3.2

Improve communication and safety in the transition of care.

ACTIONS

a) Update the guidelines on communication in the transition of care;

b) Develop and implement communication tools, for a safe transition and transfer during the provision of care, between health professionals and the different levels of care;

c) Develop specific training programmes aimed at health professionals on transfer of information during the transition of care process.

GOAL 2026

Goal 12 - 90% of health care institutions monitoring and carrying out internal audits to the communication process in the transitions of care.

INDICATOR

Goal 12

$$\frac{\text{No. of institutions conducting IA* to the communication process in the transition of care}}{\text{Total No. of eligible health care institutions}} \times 100$$

* IA - Internal Audits

Source: numerator data known by each health institution, denominator data known by the DGS (SNS health institutions).

BACK TO INDEX

2.4.3. Pillar 3. Communication

Strategic Objective 3.3

Adjust the communication of clinical information to patients, families and caregivers.

ACTIONS

a) Update the informed, clarified and freely given consent and promote its adequate use during the clinical communication process to the patient;

b) Monitor the proper use of the informed, clarified and freely given consent in the clinical communication.

GOAL 2023

Goal 13 - Publication of the updated Guideline on the informed, clarified and freely given clinical consent.

GOAL 2026

Goal 14 - 85% of institutions providing healthcare with mechanisms in place to assess, monitor and audit the patient's perception of informed, clarified and freely given clinical consent as well as of the transmitted information.

INDICATORS

Goal 13

Publication of the updated Guideline on the informed, clarified and freely given clinical consent.

Goal 14

$$\frac{\text{No. of institutions assessing the degree of patient perception of the ICFC*}}{\text{Total No. of eligible health care institutions}} \times 100$$

*ICFC –Informed, clarified and freely given clinical consent

Source: numerator data known by each health institution, denominator data known by DGS (SNS health institutions).

OTHER INDICATORS

• Number of internal audit reports carried out on the transfer of information during the transitions of care.

Source: Data known by each health institution.

2.4.4. Pillar 4.Prevention and management of safety incidents

Strategic Objective 4.1

Increase the culture and transparency when reporting patient safety incidents in the NOTIFICA system.

ACTIONS

a) Encourage the reporting of patient safety incidents associated with pharmacovigilance and haemovigilance in the NOTIFICA system, through training sessions and the provision of facilitating tools;

b) Include the reporting of safety incidents in the NOTIFICA system in the contracting targets of the healthcare institutions;

c) Publish, disseminate and implement the legal framework for the confidentiality and protection of the person reporting.

GOALS 2026

Goal 15 - 70% of the SNS healthcare institutions to include the reporting of patient safety incidents in their contracting targets;

Goal 16 - Publication of the legal framework for the confidentiality and protection of the person reporting;

Goal 17 - To increase by 20% the reporting of safety incidents.

INDICATORS

Goal 15

$$\frac{\text{No. of SNS institutions with patient safety incidents reporting included in the contracting goals}}{\text{Total number of eligible SNS healthcare institutions}} \text{ X100}$$

Source: numerator data known by each health institution and ACSS, denominator data known by DGS.

Goal 16

Publication of the legal framework for the confidentiality and protection of the person reporting;

Goal 17

$$\frac{\text{No. of SNS institutions with patient safety incidents reported}}{\text{Total number of eligible SNS healthcare institutions}} \text{ X100}$$

Source: numerator data known by DGS, denominator data known by DGS (SNS health institutions).

OTHER INDICATORS

• Number of Patient Safety incident reports in the NOTIFICA system, in the institution;

• Number of Patient Safety incident reports in internal reporting platforms (in cases where the institution has those systems in place).

Source: Data known by each health institution.

2.4.4. Pillar 4.Prevention and management of safety incidents

Strategic Objective 4.2

Promote the follow up and assessment of the patient safety incidents in the NOTIFICA system.

ACTIONS

a) Optimise the NOTIFICA as a national platform for reporting patient safety incidents;

b) Develop a module for auditing safe practices in the NOTIFICA system;

c) Implement tools and procedures for monitoring and providing feedback on safety incidents to the professionals and citizens.

GOAL 2023

Goal 18 - 100% development of the optimised version of NOTIFICA system.

GOAL 2026

Goal 19 - 100% development of the audit, monitoring and feedback module of safety incidents reported on the NOTIFICA system, to the professionals and citizens.

INDICATORS

Goal 18

Development of the optimised version of the NOTIFICA system.

Goal 19

Completing the development goals of the auditing and monitoring module and feedback of the safety incidents reported in the NOTIFICA system.

OTHER INDICATORS

- No. of reports from the internal audits carried out to the incident analysis methodology (NOTIFICA system) in the institution.

- No. of reports from the internal audits carried out on the methodology of incident analysis (internal reporting platforms), in the institution.

Source: Data known by each health institution.

2.4.5. Pillar 5. Safe Practices in Safe Environments

Strategic Objective 5.1

Implement and consolidate safe practices in a healthcare environment.

ACTIONS

a) Promote the use of digital tools for safe practices concerning safe surgery, safe childbirth, falls, pressure ulcers, patient misidentification, medication safety and medication reconciliation;

b) Standardise the use of tools for monitoring the risk of safety incidents in the provision of care at different levels of care, including at home.

GOALS 2026

Goal 20 - 90% of healthcare institutions using control and monitoring tools for safe practice related to safe surgery, falls, pressure ulcers, patient misidentification, medication safety and medication reconciliation;

Goal 21 - 90% of healthcare institutions with tools to monitor the risk of safety incidents in the provision of different levels of care, including at home.

INDICATORS

Goal 20

Note: The formula below will be applied to all safety areas listed in goal 20 (safe surgery, safe childbirth, occurrence of falls, occurrence of pressure ulcers, patient misidentification, medication safety and medication reconciliation)

$$\frac{\text{No. of HC* providers using safe practice control and monitoring tools}}{\text{Total No. of eligible SNS healthcare institutions}} \text{ X100}$$

*HC- Health Care

Source: numerator data known by each health institution, denominator data known by DGS (SNS health institutions).

Goal 21

Note: The formula below will be applied to all safety areas listed in goal 20 (safe surgery, safe childbirth, occurrence of falls, occurrence of pressure ulcers, patient misidentification, medication safety and medication reconciliation)

$$\frac{\text{No. of HC* providers with tools to monitor the risk of safety incidents in the different levels of health care, including home care}}{\text{Total No. of eligible SNS healthcare institutions}} \text{ X100}$$

*HC- Health Care

Source: numerator data known by each health institution, denominator data known by the DGS (SNS health institutions).

2.4.5. Pillar 5. Safe Practices in Safe Environments

OTHER INDICATORS

- **Safe Surgery:**
  - Non-compliance rate on the use of the institution's safe surgery checklist.
  - Surgical complication rates of never events at the institution:
    - Wrong surgical site;
    - Wrong procedure;
    - Wrong patient;
    - Retained surgical bodies after surgery ;
    - Intraoperative death in ASA 1 patients (American Society of Anaesthesiology, healthy user);
  - Number of incident reports related to surgical procedures in the institution.
- **Safe childbirth:**
  - Number of institutions with implemented activities in the safe childbirth area.
  - Number of birth-related incident reports in the institution.
- **Occurrence of falls:**
  - Number of institutions with implemented activities in fall prevention;
  - Number of falls incident related reports in the institution.
- **Occurrence of pressure ulcers:**
  - Number of institutions with implemented activities in the prevention of pressure ulcers;
  - Number of developed pressure ulcers incident related reports in the institution.
- **Patient misidentification:**
  - Number of institutions with local strategy for patient misidentification implemented;
  - Number of patient identification related reports in the institution.
- **Medication safety:**
  - Number of institutions with updated and disseminated LASA list;
  - Number of institutions with implemented institutional strategy for storage and identification of LASA medications;
  - Number of LASA medication incident reports in the institution;
  - Number of institutions with an updated list of high alert medicines;
  - Number of institutions with an implemented institutional strategy for high alert medicines;
  - Number of incident reports related to the use of high alert medicines in the institution.

Source: Data known by each health institution

2.4.5. Pillar 5. Safe Practices in Safe Environments

Strategic Objective 5.2

Monitor the implementation of safe practices.

ACTIONS

a) Update the guidelines in the patient safety area;

b) Have an annual audit regarding safe practices related to safe surgery, safe childbirth, falls, pressure ulcers, patient misidentification and medication safety;

c) Develop and implement the Contingency Plans for Public Health Emergencies, with special attention to the area of patient safety.

GOAL 2023

Goal 22 - 100% of health institutions with Contingency Plans for Public Health Emergencies

GOALS 2026

Goal 23 - 90% of healthcare institutions with defined strategies for implementing safe practices in the following areas: safe surgery, safe, childbirth, falls, pressure ulcers, healthcare-associated infections

Goal 24 - 90% of health institutions with annual internal audits carried out and the reports published on the institutional website.

INDICATORS

Goal 22

$$\frac{\text{No. of health care institutions with Contingency Plans for Public Health Emergencies}}{\text{No. of eligible health care institutions}} \times 100$$

Source: numerator data known by each health institution, denominator data known by DGS (SNS health institutions).

Goal 23

Note: The formula below will be applied to all safety areas listed in goal 20

$$\frac{\text{No. of health care institutions with defined strategies for the implementation of safety practices in PS* areas}}{\text{No. of eligible health care institutions}} \times 100$$

*PS - Patient Safety

Source: numerator data known by each health institution, denominator data known by DGS (SNS health institutions).

2.4.5. Pillar 5. Safe Practices in Safe Environments

Strategic Objective 5.2 (continued)

Monitor the implementation of safe practices.

INDICATOR

Goal 24

$$\frac{\text{No. of healthcare institutions with annual internal audits and reports available in the institutional website}}{\text{No. of eligible health care institutions}} \times 100$$

Source: numerator data known by each health institution, denominator data known by the DGS (SNS health institutions).

BACK TO INDEX

2.4.5. Pillar 5. Safe Practices in Safe Environments

OTHER INDICATORS

- **Safe Surgery:**
  - Number of reports of internal audits carried out annually within the scope of safe surgery, in the institution.
- **Safety in childbirth:**
  - Number of reports of internal audits carried out annually in the safe childbirth area.
- **Occurrence of falls:**
  - Number of reports of internal audits carried out annually within the scope of fall prevention, in the institution.
- **Occurrence of pressure ulcers:**
  - Number of reports of internal audits carried out annually in the institution for the prevention of pressure ulcers.
- **Patient misidentification:**
  - Number of internal audit reports carried out annually on patient misidentification in the institution.
- **Medication safety:**
  - Number of reports of internal audits carried out annually within the medication safety in the institution.
- **Others:**
  - Number of internal audit reports carried out annually on the Allergy Registry.

Source: Data known by each health institution.

2.4.5. Pillar 5. Safe Practices in Safe Environments

Strategic Objective 5.3

Reduce healthcare-associated associated infections (HAIs) and antimicrobial resistance (AMR).

ACTIONS

a) Promote the adherence of health institutions to the multimodal strategy on basic precautions for infection control, as recommended by PPCIRA;

b) Implement the PPCIRA epidemiological surveillance programmes for HAIs;

c) Uphold and enable the services to implement and monitor the HAIs prevention bundles;

d) Promote the implementation of the Antimicrobial Stewardship Programs, using and developing restrictive and training methodologies, both educational and behavioural;

e) Ensure the allocation of protected time to professionals involved in the prevention, control and monitoring of HAIs and in the operationalization of the Antimicrobial Stewardship Programs in health institutions, in accordance with Order no. 15423/2013, of 26 November;

f) Share with health professionals the results of the outcome and process indicators defined for the HAIs, Antimicrobial Consumption (AMC) and AMR areas, and their relations with the implementation of quality improvement interventions.

GOALS 2026

Goal 25 - 95% of hospitals with epidemiological surveillance of HAIs, AMC and AMR;

Goal 26 - 95% of hospitals with Antimicrobial Stewardship Programs implemented;

Goal 27 - Reduce by at least 30% the incidence of catheter-associated urinary tract infection, central venous catheter-associated bloodstream infection, ventilation-associated pneumonia and surgical site infection, in each hospital or healthcare unit (when applicable);

Goal 28 - Reduce to less than 10% the rate of carbapenem-resistant K. pneumoniae;

Goal 29 - Reduce by at least 10% the consumption of antibiotics in ambulatory care;

Goal 30 - 95% of the health units with adherence to the first moment of hand hygiene.

INDICATORS

Goal 25

$$\frac{\text{No. of hospital units with epidemiological surveillance programmes for HAIs, AMR and AMC implemented}}{\text{Total No. of eligible hospital units}} \times 100$$

Note: "Hospital units with implemented epidemiological surveillance programmes" means those carrying carry out at least one HAI Epidemiological Surveillance (ES) programme for the minimum period of three months in a year and carry out AMR ES programme of (PPCIRA/INSA) and AMC (PPCIRAINFARMED), on an annual basis.

Source: Data for the numerator provided by each hospital unit to the PPCIRA and data for the denominator provided by ACSS.

BACK TO INDEX

2.4.5. Pillar 5. Safe Practices in Safe Environments

Strategic Objective 5.3 (continued)

Reduce healthcare-associated associated infections (HAIs) and antimicrobial resistance (AMR).

INDICATORS

Goal 26

$$\frac{\text{No. of health units with Antimicrobial Stewardship Programs}}{\text{Total No. of eligible health units}} \text{ X100}$$

Source: Data for the numerator provided by the GLC-PPCIRA in each health unit to the PPCIRA and data for the denominator provided by the ACSS.

Goal 27

$$\frac{\text{Number of new cases of CAUTI* in the considered time period}}{\text{Number urinary catheter-days quantified in the same period}} \text{ X1000}$$

*CAUTI - Catheter-associated urinary tract infections: Data provided by GLC-PPCIRA to PPCIRA

Source: Data provided by GCL-PPCIRA to the PPCIRA

$$\frac{\text{Number of new cases of CVC bloodstream associated infection in the considered period of time}}{\text{No. of central venous catheter-days quantified in the same period}} \text{ X1000}$$

Source: Data provided by GCL-PPCIRA to the PPCIRA

$$\frac{\text{Number of new cases of VAP in the time period considered}}{\text{No. of days of endotracheal tube quantified in the same period}} \text{ X1000}$$

Source: Data provided by GCL-PPCIRA to the PPCIRA

$$\frac{\text{No. of new episodes of surgical site infection in the time period considered}}{\text{Total number of patients submitted to this surgical procedure in the same period}} \text{ X100}$$

Note: Breakdown the indicator for each of the infections monitored by the ECDC and included in the epidemiological surveillance of the surgical site (cholecystectomies, colon and rectal surgeries, caesarean sections, hip and knee replacements, laminectomies and those associated with coronary bypass).

Source: Data provided by GCL-PPCIRA to the PPCIRA

Goal 28

$$\frac{\text{No. of carbapenem-resistant Klebsiella pneumoniae isolated in invasive specimens}}{\text{Total number of Klebsiella pneumoniae isolated in invasive specimens in the same time period}} \text{ X100}$$

Note: The indicator is measured annually, but its achievement depends on the reduction rate obtained by comparing 2021 and 2026.

Source: INSA, data for numerator and denominator.

2.4.5. Pillar 5. Safe Practices in Safe Environments

Strategic Objective 5.3 (continuação)

Reduce healthcare-associated associated infections (HAIs) and antimicrobial resistance (AMR).

INDICATORS

Goal 29

$$\frac{[(\text{Antibiotic consumption in DDD*, in 2026}) - (\text{Antibiotic consumption in DDD*, in 2021})]}{(\text{Antibiotic consumption in DDD* in 2021})} \text{ X100}$$

* DDD - Defined Daily Dose per 1000 inhabitants per day

Source: INFARMED

Goal 30

$$\frac{\text{No. of opportunities to comply with the first moment of HH* observed and complied with}}{\text{No. of opportunities to comply with the first moment of HH* observed}} \text{ X100}$$

*HH – Hand Hygiene

$$\frac{\text{No. of health units with adherence indicator higher than or equal to 95\%.}}{\text{Total number of health units}} \text{ X100}$$

Source: INFARMED

Strategic Objective 5.4

Promoting safe telehealth

ACTION

a) Elaborate and implement a guideline on telehealth, ensuring the best practices in the patient safety area.

GOAL 2023

Goal 31 - Publish the Guideline on telehealth.

INDICATOR

Publication of the Guideline on telehealth.

2.4.6. Indicator Timetable

INDICATORS	TIMETABLE				
PILLARS	**2022**	**2023**	**2024**	**2025**	**2026**
1. Safety Culture					
No. of healthcare institutions with annual and multi-professional training plans in the patient safety area.	X	X	X	X	X
Full review of the safety culture assessment form in cooperation with the CQS.		X			
No. of health care units with the ACS questionnaire implemented.			X	X	X
No. of healthcare institutions with at least one annual awareness-raising action aimed at patients, families and caregivers;	X	X	X	X	X
Annual nationwide patient safety communication campaign.	X	X	X	X	X
2. Leadership and Governance					
No. of hospital institutions with patient safety indicators in the contracting agreements.			X	X	X
No. of Primary Health Care units with patient safety indicators in the contracting agreements.			X	X	X
Publication of the revised legal framework of the CQS.		X			
3. Communication					
No. of ACES with access to the hospital's discharge notes.	X	X	X	X	X
No. of services and/or institutions in the SNS with digital records of the discharge and transfer notes, through the Electronic Health Records, in accordance with Order no. 2784/2013, of 20 February.	X	X	X	X	X
No. of institutions conducting internal audits of the communication process in the transition of care.	X	X	X	X	X
Publication of the updated Guideline on the informed, clarified and freely given clinical consent.		X			
No. of institutions to assess the patient's perception of the informed, clarified and freely given clinical consent.	X	X	X	X	X
No. of internal audit reports carried out on the transfer of information during the transitions of care.	X	X	X	X	X
4. Prevention and management of safety incidents					
No. of the SNS healthcare institutions to include the reporting of patient safety incidents in their contracting targets.	X	X	X	X	X
Publication of the legal framework for the confidentiality and protection of the person reporting.				X	
No. of healthcare institutions reporting patient safety incidents.	X	X	X	X	X
No. of patient safety incident reports in the NOTIFICA system and internal platforms.	X	X	X	X	X
Development of the optimized version of NOTIFICA system.	X			X	
Development of the audit, monitoring and feedback module of safety incidents reported on the NOTIFICA system, to the professionals and citizens.					X
No. of internal audit reports carried out on the incident analysis methodology (NOTIFICA system and internal platforms), in the institution.	X	X	X	X	X

BACK TO INDEX

2.4.6. Indicator Timetable (continued)

INDICATORS	TIMETABLE				
PILLARS	2022	2023	2024	2025	2026
5. Safe practices in safe environments					
No. of healthcare institutions using control and monitoring tools for safe practice related to safe surgery, falls, pressure ulcers, patient misidentification, medication safety and medication reconciliation.	X	X	X	X	X
No. of healthcare institutions with tools to monitor the risk of safety incidents in the provision of different levels of care, including at home.	X	X	X	X	X
No. of health institutions with Contingency Plans for Public Health Emergencies.	X	X	X	X	X
No. of healthcare institutions with defined strategies for implementing safe practices in the following areas: safe surgery, safe, childbirth, falls, pressure ulcers, healthcare-associated infections, patient misidentification, medication safety and medication reconciliation.	X	X	X	X	X
No. health institutions with annual internal audits carried out and the reports published on the institutional website.	X	X	X	X	X
No. of hospitals of hospitals with epidemiological surveillance of HAIs, AMC and AMR implemented (in the European and national networks) and assessed in an integrated manner.	X	X	X	X	X
No. of health units with Antimicrobial Stewardship Programs implemented and active.	X	X	X	X	X
No. of new cases of hospital-acquired urinary tract infection (UTI) and associated to urinary catheter-days per 1000 days in the considered time period.	X	X	X	X	X
No. of new cases of hospital acquired central venous catheter bloodstream associated infection per 1000 CVC days, in the time period under consideration.	X	X	X	X	X
No. of new cases of endotracheal tube associated pneumonia per 1000 days of endotracheal tube, in the time period considered.	X	X	X	X	X
No. of new episodes of surgical site infection per number of surgeries performed, in the time period considered.	X	X	X	X	X
No. of health units participating in the epidemiological surveillance of problem and alert microorganisms, determined by PPCIRA/DGS and based at the Instituto Nacional de Saúde Dr. Ricardo Jorge (INSA)	X	X	X	X	X
Rate of Klebsiella pneumoniae resistant to carbapenems (No. carbapenem-resistant Klebsiella pneumoniae/total of Klebsiella pneumoniae), isolated in invasive samples.	X	X	X	X	X
Rate of compliance with the first moment of hand hygiene (No. of opportunities observed and complied with / No. of opportunities observed).	X	X	X	X	X
No. of health units adhering to the Multimodal Strategy on Basic Precautions for Infection Control (MSBPIC) (includes monitoring the hand hygiene and use of gloves and global audit to the MSBPIC).	X	X	X	X	X
No. of health units to comply with the first moment of hand hygiene higher or equal to 90%.	X	X	X	X	X
No. of hospitals with annual antibiotic consumption lower than the antibiotic consumption in that same hospital in 2021 (in DHD and in DDD per patient days).	X	X	X	X	X
Publish the Guideline on telehealth.		X			
*"Other Indicators" on pages 53, 54, 55, 57 and 60 to be reported annually.	X	X	X	X	X

Note: Please refer to chapter 2.3 for the identification of those responsible, and chapter 2.4 for the identification of indicators

BACK TO INDEX

Plano Nacional para a Segurança dos Doentes

2021 | 2026

REPÚBLICA PORTUGUESA
SAÚDE

SNS
SERVIÇO NACIONAL DE SAÚDE

DGS desde 1899
Direção-Geral da Saúde