Patient Safety in Europe: Measuring progress for better and safer healthcare for all
The cost of patient harms

About one in ten patients is harmed at one point during their treatments. Patient harm is the 14th leading cause of the global disease burden. Over 37 000 people in the EU die as a result of a healthcare-associated infections (HAIs) every year in the EU. The cost of harm to patients, healthcare systems and societies is considerable. Overall, the available evidence suggests that 15% of hospital expenditures and activities in OECD countries can be attributed to treating safety failures. These alarming figures are likely to be conservative ones as data on adverse events are not available and harm to patients is chronically under-reported.¹

Furthermore, consequences resulting from patient harm are then felt in the broader economy through lost capacity and productivity of patients and their carers.²

In the political economy, the cost of safety failure includes loss of trust in the health systems, in governments and in social institutions.³

To guide the debate on how to achieve better standards regarding patient safety, antimicrobial resistance (AMR) and healthcare associated infections in Europe, Health First Europe has developed 11 policy indicators to measure progress on patient safety policy including prevention and control of healthcare associated infections at EU level. Based on the European Council Recommendations (2009) on patient safety, including the prevention and control of healthcare-associated infections in the EU, these indicators cover a broad range of areas from general patient safety and HAIs policies, to areas like education of healthcare workers, patient empowerment and surveillance programmes.

² It is estimated that the aggregate costs amount to trillions of dollars each year.
HFE 11 patient safety indicators

1. Membership in HAI Network (ECDC)
2. Patient safety policy
3. Surveillance and screening programmes
4. Implementation of the WHO’s campaign
5. Target setting
6. Incident reporting
7. Data gathering
8. Healthcare facility infrastructure
9. Education and training
10. Patient literacy and empowerment
11. Incentivising innovation in HAI/AMR reduction
Executive Summary

Methodology

HFE truly believes that clear patient safety benchmarking indicators can accelerate the implementation of EU Patient Safety policies by facilitating better uptake of best practices across EU Member States. This would serve the purpose of striving towards high-quality healthcare systems designed around the safety of patients. To assess the implementation of patient safety policies across Europe, Health First Europe carried out an in-depth analysis in 7 EU Member States, namely Italy, France, Belgium, Germany, the UK, the Netherlands and Spain.

The analysis included:

Website monitoring
Monitoring national Ministries and national health institutions’ websites to map the existence and accessibility of national policies and data on patient safety, screening and surveillance programmes etc.

Off-line survey
Development of a dedicated survey for patient and professional organisations active in the field of patient safety was used to validate date and information gathered through website monitoring.

Phone interviews
Direct contact with national health ministries to mapping the existence and evaluate the impact of national healthcare policies on patient safety.

What has emerged is an alarming lack of clarity in the national legal frameworks on patient safety, healthcare-associated infection prevention and screening programmes. Information provided by national health Ministries’ websites is incomplete. National associations are poorly aware of all aspects of national policy on patient safety in their country. Another element which is worth considering is the divergence amongst the answers provided by patients and healthcare professionals’ representatives of a given country. For many of the associations operating in Italy, France and the Netherlands, patient safety and HAIs prevention practices are still unclear.

Patient safety strategies are rarely implemented in isolation. Adopting and implementing safety strategies requires vision and leadership across all levels of the healthcare systems, beginning with Ministers. In this regard, the following report calls on European policymakers to become the driver of the patient safety culture in Europe.
Main findings

Overview
The European Council Recommendations (2009) on patient safety, including the prevention and control of healthcare-associated infections in the EU, have raised awareness on the gravity of issue and pushed EU Member States to develop patient safety policy at the national and regional level. Nevertheless, these Recommendations are far behind from being effectively and correctly implemented in Europe.

As shown by HFE mapping, there is a high level of uncertainty about the implementation of policies and programmes on patient safety, including prevention and control of healthcare associated infection along with a very limited patients’ access to data and information on such programmmes.

First of all, information provided by national health ministries’ websites is incomplete. Official websites do not offer a clear understanding of national policy and / or patients’ rights. HFE liaised with a total of 41 healthcare actors (including patient and professional associations, national health institutes and research centres) [ANNEX I]. Most of them do not have adequate information to reply to the whole survey about patient safety measures in their countries. Only 26% has been able to fill in the survey providing a comprehensive evaluation. Another element which is worth considering is the divergence amongst the answers provided by patients and healthcare professionals’ representatives of a given country. For many of the associations operating in Italy, France and the Netherlands, many matters relating to patient safety and HAIs prevention are still unclear. Sadly, patients cannot have access to patient safety data, information and best practices.

Implementation of screening programmes for HAIs
Health First Europe indicators highlight how the implementation of screening programmes for HAIs (which are critical to reduce infection spread) is still lagging behind in many EU countries. According to our data, Belgium does not have a standardised screening programme and in the UK it is still not clear whether screening programmes

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<tbody>
<tr>
<td>Federación de Mujeres con Cáncer de Mama (FEC-MA)</td>
<td>Federación Nacional ALCER</td>
<td>Cittadinanza Attiva (ACN)</td>
<td>Federazione Medici (FM)</td>
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<tr>
<td>Does your country have a standardised HAI screening programme?</td>
<td>Don’t know</td>
<td>No</td>
<td>No</td>
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Reduction rate targets

The reduction rate targets are perceived to be effective tools to track improvements and ensure patient safety remain a high priority within healthcare settings. The research puts forward a worrying level of uncertainty with regards to the target rates on surgical site infections, HAIs in intensive care units and long-term care facilities, clostridium difficile infections, methicillin-resistant Staphylococcus aureus (MRSA) infections and Carbapenemase-producing Enterobacteriaceae. The current situation in all 7 EU member States is muddled with contradictory answers, data and information. Italy, France and Germany present the most unclear legal frameworks.

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Has your country set a reduction rate target for:

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<th></th>
<th>Belgium</th>
<th>France</th>
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<tbody>
<tr>
<td>Surgical site infections</td>
<td>Yes</td>
<td>Yes</td>
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<td>Yes</td>
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<tr>
<td>HAIs in intensive care units</td>
<td>Yes</td>
<td>Yes</td>
<td></td>
<td>Don’t know</td>
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<tr>
<td>HAIs in long-term care facilities</td>
<td>Yes</td>
<td>Yes</td>
<td></td>
<td>Don’t know</td>
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<tr>
<td>Clostridium difficile infections</td>
<td>Yes</td>
<td>No</td>
<td></td>
<td>Don’t know</td>
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<tr>
<td>MRSA infections</td>
<td>Yes</td>
<td>Yes</td>
<td></td>
<td>Don’t know</td>
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<tr>
<td>CPE</td>
<td>Yes</td>
<td>No</td>
<td></td>
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<tr>
<td>Infections caused by other MDRO (eg. Gramnegatives, TB)</td>
<td>No</td>
<td>No</td>
<td></td>
<td>Don’t know</td>
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</table>
Implementation of standardised surveillance programmes

Another crucial contribution in the field of patient safety lies in the design and implementation of standardised surveillance programmes, currently in place in Belgium, Spain, France, Germany, the UK and the Netherlands. Italy has put in place few surveillance programmes at the regional level but there is no homogeneity and clarity according to the data collected so far.

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<tr>
<td></td>
<td>Saint Luc</td>
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After the adoption of the Council Recommendation 2009/C 151/01 on patient safety, including the prevention and control of healthcare-associated infections, patient safety has become an integral part of the formal education pathway for healthcare professionals. Education and training courses for healthcare workers are vital to raise awareness on patient safety matters, patient empowerment as well as on the relationship between healthcare professionals and individuals. However, the current situation is far from being ideal.
Patient literacy and empowerment

European countries like Spain, France and Italy do not have a dedicated person responsible for patient safety in their regions. Secondly, patients do not seem to be proactively involved in awareness trainings for HAIs, AMR and adverse events. This occurs in France and Italy. Dutch patient associations also pointed out a lack of information regarding safety in healthcare settings. There is a mechanism in place for reporting of incidents for professionals which exists in Germany, Italy, France, the Netherlands and Spain but it is not clear whether it is mandatory and doesn't always include patients. A good reporting system of incidents and adverse events could contribute to build a blame-free culture in all healthcare settings. Furthermore, statistics on adverse events are hardly made publicly available. As a result, patient empowerment is still an unmet target and much more needs to be done to create an equitable and transparent process for recognizing and avoiding errors in healthcare settings. Getting information is critical to patient safety issues and the more accurate statistics are, the more willing patients will be to provide information. (See annex II).

Improving patient safety in Europe – the way forward

According to the answers received by national health stakeholders, awareness raising campaigns are perceived to be the most effective tools to foster patient safety, followed by binding legislation and joint initiatives. Please see the graphs below:
In the Council Conclusions 2014/C 438/05, the Italian Presidency invited EU Member States and the Commission to intensify their efforts and work - among others - on promoting patient safety culture, dimensions of quality of healthcare, patient involvement in patient safety strategies and methodologies of establishing patient safety standards. However, this has been only partially achieved. **Patient safety still remains a major challenge in healthcare settings across Europe**, as also highlighted in the European Commission’s Report on the implementation of the Council Recommendation on patient safety issued in 2014. The costs of failure on patient safety are significant not only for patients and their loved ones, but it also generates a considerable burden on health system finances. At least, 15% of hospital expenditure and activity in OECD countries can be attributed to treating safety failures.

Therefore, patient safety must remain a critical policy concern and an important challenge to solution for all EU Member States. **With 30-70% potentially preventable adverse events** by putting together adequate patient safety measure, **investing in patient safety is critical to reduce waste, release resources and make the case for more efficient and effective health systems in Europe.**

**According to the OECD studies:**

- **Greater investment in prevention is justified.** Many adverse events can be systematically prevented through better policy and practice, with the cost of prevention typically much lower than the cost of harm. It is estimated that in the United States, USD 28 Billion have been saved between 2010 and 2015 by systematically improving safety.

- **Solid foundations for patient safety need to be in place.** A hierarchy of programs and interventions to improve safety should exist. A national value-based approach - where harm is reduced using limited resources - should begin with investing in fundamental system-level initiatives such as professional education and training, safety standards and a solid information infrastructure.

- **Active engagement of providers and patients is critical.** Organisational-level initiatives such as clinical governance frameworks, patient–engagement and building a positive safety culture also forms an important part of an integrated patient safety strategy.

- **Innovation at the clinical level is enhanced through national leadership.** With these structural reforms in place, micro-level interventions to prevent specific adverse event types at the clinical practice level can be implemented to minimise harm.
Conclusion

Patient safety strategies are rarely implemented in isolation. **Adopting and implementing safety strategies requires vision and leadership across all levels of the healthcare systems, beginning with Ministers.** In this regard, we call on European policymakers to become the driver of a patient safety culture in Europe.

**It is critical for European policymakers to:**

**SUPPORT** the creation of common terminology, indicators and research on patient safety.

**MONITOR** and support Member States implementation of strategies and programmes to prevent adverse events in all settings of care through guidelines on how to build patient safety and quality of care standards.

**FACILITATE** healthcare providers and patients’ access to data and best practices to offer concrete solutions to reduce patient harms.

**RAISE AWARENESS** on patient safety at political level and trigger concrete actions aimed at ensuring a high level of coordination of EU activities and participation of national governments in EU surveillance of healthcare-associated infections as coordinated by the ECDC.

**ENCOURAGE** reporting as a tool to spread a patient safety culture.
ANNEX I

HFE Outreach – highlighted in yellow are the associations that were able to fill in all survey questions

The United Kingdom
The Patients Association
British Nursing Association National Voices
British Heart Foundation
Action against Medical Accidents
IAPO
The King’s Fund
the Health Foundation
NHS Improvement

Spain
Federación Nacional ALCER
EsCronicos - Estudio de Acceso a una Atención de Calidad de los Pacientes Crónicos Españoles
Federación Española de Cáncer de Mama (FECMA)
Asociación Española de Pacientes con Cefalea
CardioAlianza - Organizaciones de pacientes con enfermedades cardiovasculares (ECV)
Somos Pacientes
AEEQ - Spanish Association of Surgical Nursing
Spanish Scleroderma Association
Federación de Mujeres con Cáncer de Mama (FECMA)

The Netherlands
National Association of General Practitioners (LHV)
Nederlandse vereniging voor Kindergeneeskunde (NVK)
Dutch League Ass. Rheumatic Disorder
NIVEL, Netherlands Institute for Health Services Research

France
Inserm
Conseil nationale de l’Ordre des Médecins (COM)
Société Française de Microbiologie
Société de pathologie infectieuse de langue française

Germany
Robert Koch Institute
German Nurses Association
German Hospital Federation
Association of Specialists of Germany (SPIFA)
Federal Ministry of Health
German Medical Association
Hartmannbund
Aktionbuendnis Patientensicherheit (Patient Safety alliance)
GKV Spitzenverband (Federal Association of Sickness Funds)

Belgium
Belgian Foundation against Cancer | UICC
Brussels-Capital Health and Social Observatory
Laboratoires des Cliniques universitaires Saint-Luc – Unité de microbiologie
Prof. dr. Willem-Jan Metsemakers Wilhelms, Surgeon-traumatologist
Prof. dr. Lieven Annemans, Full Professor in Health Economics

Italy
Cittadinanza Attiva
Federazione Nazionale degli Ordini dei Medici chirurghi e degli Odontoiatri
## ANNEX II

### Research outcome

#### BELGIUM

<table>
<thead>
<tr>
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<th>Ministry of Health</th>
</tr>
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<tbody>
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<table>
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<td>Yes</td>
<td>Yes</td>
<td>Yes</td>
</tr>
<tr>
<td>On a scale of 1-10 (1 being not important, and 10 being very important), what level of importance does your organisation give to the issue of patient safety and healthcare associated infections (HAIs)?</td>
<td>Not relevant</td>
<td>8</td>
<td>8</td>
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<tr>
<td>Does the member state have a national policy on:</td>
<td></td>
<td></td>
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<tr>
<td>- Patient safety?</td>
<td>Yes</td>
<td>Yes</td>
<td>Yes</td>
</tr>
<tr>
<td>- HAIs?</td>
<td>Yes</td>
<td>Yes</td>
<td>Yes</td>
</tr>
<tr>
<td>- Antimicrobial Resistance?</td>
<td>Yes</td>
<td>Yes</td>
<td>Yes</td>
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<tr>
<td>- Multi-drug resistance organisms (MDRO)</td>
<td>Yes</td>
<td>Yes</td>
<td>Yes</td>
</tr>
<tr>
<td>Is there a standardised screening programme for HAIs in the member state?</td>
<td>Yes</td>
<td>Yes</td>
<td>Do not know</td>
</tr>
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<td>Does your country have a standardised screening programme for the following micro-organisms?</td>
<td></td>
<td></td>
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<tr>
<td>- Clostridium difficile</td>
<td>No</td>
<td>Yes</td>
<td>No answer</td>
</tr>
<tr>
<td>- Methicillin-resistant staphylococcus aureus (MRSA)</td>
<td>Yes</td>
<td>Yes</td>
<td>No answer</td>
</tr>
<tr>
<td>- Methicillin-sensitive staphylococcus aureus (MSSA)</td>
<td>Yes</td>
<td>No</td>
<td>No answer</td>
</tr>
<tr>
<td>- Carbapenemaseproducing enterobacteriaceae (CPE)</td>
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<td>Yes</td>
<td>No answer</td>
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<tr>
<td>Use of existing material:</td>
<td></td>
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<tr>
<td>- Is the WHO surgical safety checklist used at national level?</td>
<td>Yes</td>
<td>Yes</td>
<td>No</td>
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<tr>
<td>- Was the WHO save lives: clean your hands campaign promoted nationally?</td>
<td>No</td>
<td>No</td>
<td>Yes</td>
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<tr>
<td>- Have the WHO guidelines on hand hygiene in health care been implemented?</td>
<td>Yes</td>
<td>No</td>
<td>Yes</td>
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**BELGIUM**

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</tbody>
</table>

**Name of the association**

**Has the member state set a reduction rate target for:**

- **CPE**
  - No
  - No
  - Yes
  - No answer
- **Infections caused by other mdro (eg. Gramnegatives, tb, ...)**
  - No
  - No
  - Yes
  - No answer
- **Surgical site infections**
  - No
  - No
  - No
  - No answer
- **HAIs in intensive care units**
  - No
  - No
  - Yes
  - No answer
- **HAIs in long term facilities**
  - No
  - No
  - No
  - No answer
- **Clostridium difficile infections**
  - No
  - No
  - No
  - No answer
- **MRSA infections**
  - No
  - Yes
  - Yes
  - No answer

**Is there a mandatory mechanism in place for reporting of incidents for:**

- **Professionals?**
  - Yes
  - Yes
  - Yes
  - No answer
- **Patients?**
  - Yes
  - No
  - No
  - No answer

**Does your country have a standardised surveillance programme for hais?**

**Are statistics on adverse events published?**

<table>
<thead>
<tr>
<th>Yes</th>
<th>Yes</th>
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<td>No</td>
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<tr>
<th>Yes</th>
<th>Yes</th>
<th>Yes</th>
<th>Yes</th>
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</table>

**Is patient safety incorporated into the curricula for:**

- **Doctors**
  - No
  - No
  - Yes
  - No answer
- **Nurses**
  - No
  - Yes
  - Yes
  - No answer
- **Carers**
  - No
  - No
  - Yes
  - No answer

**Is continuous training provided to hospital or healthcare facility staff on how to effectively combat HAIs and adverse events?**

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<th>No</th>
<th>Yes</th>
<th>Yes</th>
<th>Do not know</th>
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<td>No</td>
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<td>Do not know</td>
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<tr>
<td>No</td>
<td>No</td>
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**Are patients proactively involved into awareness trainings on HAIs, AMR and adverse events?**

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<tr>
<th>No</th>
<th>Yes</th>
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<td>HEALTH INSPECTORATE FOR BRUSSELS-CAPITAL REGION</td>
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</table>

In your opinion, which are the best tools and provisions to address patient safety at EU level?

- **Non-binding legislation**: No relevant | No | Yes | No
- **Binding legislation**: No relevant | No | No | No
- **Decree/regulation**: No relevant | No | No | Yes
- **Awareness raising campaign**: No relevant | No | Yes | Yes
- **Publications**: No relevant | No | Yes | No
- **Joint initiatives (i.e. Joint Action on patient safety)**: No relevant | Yes | No | No

In your opinion, which are the best tools and provisions to address patient safety at national level?

- **Non-binding legislation**: Not relevant | No | Yes | No
- **Binding legislation**: Not relevant | Yes | No | No
- **Decree/regulation**: Not relevant | No | No | Yes
- **Awareness raising campaign**: Not relevant | Yes | Yes | Yes
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### References

- Commission belge de coordination de la politique antibiotique
- BAPCOC
- https://bmjopen.bmj.com/content/5/2/e006916.full
- https://ec.europa.eu/health/home_en
- https://qualitysafety.bmj.com/content/21/9/760
- https://www.hspm.org/countries/belgium25062012/livinghit.aspx?Section=2.9%20Patient%20empowerment&Type=Section
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Research outcome

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<tr>
<th>Does the member state have a national policy on:</th>
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<th>Yes</th>
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In your opinion, which are the best tools and provisions to address patient safety at EU level?

- Non-binding legislation  
  - Not relevant 
  - Not relevant 
  - Not relevant 
  - Not relevant
  - Not keen to answer

- Binding legislation  
  - Not relevant 
  - Yes 
  - Yes 
  - Not keen to answer

- Decree/regulation  
  - Not relevant 
  - Yes 
  - Yes 
  - Not keen to answer

- Awareness raising campaign  
  - Not relevant 
  - Yes 
  - No 
  - Not keen to answer

- Publications  
  - Not relevant 
  - No 
  - Yes 
  - Not keen to answer

- Joint initiatives (i.e. Joint Action on patient safety)  
  - Not relevant 
  - Yes 
  - No 
  - Not keen to answer

In your opinion, which are the best tools and provisions to address patient safety at national level?

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  - No 
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References

National/regional systems for surveillance of healthcare-associated infections.
http://www.who.int/bulletin/volumes/89/1/11-030111/en/
Prudent use of antimicrobial agents in human medicine.
Awareness campaigns started in 2002
Patient safety activities in France
WHO Surgical Safety Checklist
Actions on Hand Hygiene
Current situation on specific targets at regional level
ECDC actions on AMR
Reporting and Learning systems at regional and local level
https://ec.europa.eu/health/home_en
https://en.wikipedia.org/wiki/Hospital-acquired_infection#France
Overall data gathering system
ECDC publication 2013
http://www.ncbi.nlm.nih.gov/pmc/articles/PMC2464964/
http://www.cclinparisnord.org/Usagers/accueil/Acc.htm
ANNEX II

Research outcome

**GERMANY**

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**Is the member state a part of the HAI-net (ECDC)?**
Yes
Not keen to answer
Yes

**On a scale of 1-10 (1 being not important, and 10 being very important), what level of importance does your organisation give to the issue of patient safety and healthcare associated infections (HAIs)?**
Not keen to answer
10

**Does the member state have a national policy on:**

- **Patient safety?**
  - Yes
  - Not keen to answer
  - Yes

- **HAIs?**
  - Yes
  - Not keen to answer
  - Yes

- **Antimicrobial resistance?**
  - Yes
  - Not keen to answer
  - Yes

- **Multi-drug resistance organisms (MDRO)**
  - Yes
  - Not keen to answer
  - Yes

**Is there a standardised screening programme for HAIs in the member state?**
Yes
Not keen to answer
Yes

**Does your country have a standardised screening programme for the following micro-organisms?**

- **Clostridium difficile**
  - Not keen to answer
  - No

- **Methicillin-resistant staphylococcus aureus (MRSA)**
  - Not keen to answer
  - Yes

- **Methicillin-sensitive staphylococcus aureus (MSSA)**
  - Not keen to answer
  - No

- **Carbapenemaseproducing enterobacteriaceae (CPE)**
  - Not keen to answer
  - Yes

**Use of existing material:**

- **Is the WHO surgical safety checklist used at national level?**
  - Yes
  - Not keen to answer
  - Yes

- **Was the WHO save lives: clean your hands campaign promoted nationally?**
  - Yes
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  - Yes

- **Have the WHO guidelines on hand hygiene in health care been implemented?**
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#### Has the member state set a reduction rate target for:

- **CPE**
- **Infections caused by other MDRO (eg. Gramnegatives, TB, ...)**
- **Surgical Site Infections**
- **HAIs in intensive care units**
- **HAIs in long term facilities**
- **Clostridium difficile infections**
- **MRSA infections**

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#### Is there a mandatory mechanism in place for reporting of incidents for:

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- **Patients?**

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#### Does your country have a standardised surveillance programme for HAIs?

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#### Are statistics on adverse events published?

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#### Does each hospital or healthcare facility have a dedicated person responsible for patient safety?

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#### Is patient safety incorporated into the curricula for:

- **Doctors**
- **Nurses**
- **Carers**

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#### Is continuous training provided to hospital or healthcare facility staff on how to effectively combat HAIs and adverse events?

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#### Are patients proactively involved into awareness trainings on HAIs, AMR and adverse events?

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#### Are the use of processes and technologies that improve efficiency and cost-effectiveness in patient safety incentivized by reimbursement structures?

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In your opinion, which are the best tools and provisions to address patient safety at EU level?

- Non-binding legislation  
  Not keen to answer  
  No
- Binding legislation  
  Not keen to answer  
  No
- Decree/regulation  
  Not keen to answer  
  No
- Awareness raising campaign  
  Not keen to answer  
  Yes
- Publications  
  Not keen to answer  
  Yes
- Joint initiatives (i.e. Joint Action on patient safety)  
  Not keen to answer  
  Yes

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References

Healthcare-associated Infections Surveillance Network (HAI-Net)
German policy on Patient safety
German Patient Safety Law
https://www.bundesgesundheitsministerium.de/themen/krankenversicherung/stationaere-versorgung/qualitaetssicherung.html
https://www.bundesgesundheitsministerium.de/themen/krankenversicherung/stationaere-versorgung/krankenhaushygiene.html
Strategy for the identification, prevention and control of antimicrobial resistance (DART)
WHO Guidelines in Germany
Policy on reporting possible complaints on mistakes made during operations, or while being under medical care
https://www.ifpsbonn.de/
## ITALY

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- Yes
- Not keen to answer

### On a scale of 1-10 (1 being not important, and 10 being very important), what level of importance does your organisation give to the issue of patient safety and healthcare associated infections (HAIs)?
- 10
- 9
- Not keen to answer

### Does the member state have a national policy on:

- **Patient safety?**
  - Yes
  - Yes
  - Yes
  - Not keen to answer

- **HAIs?**
  - Yes
  - Yes
  - No
  - Not keen to answer

- **Antimicrobial resistance?**
  - Yes
  - Yes
  - No
  - Not keen to answer

- **Multi-drug resistance organisms (MDRO)**
  - Yes
  - Yes
  - No
  - Not keen to answer

### Is there a standardised screening programme for HAIs in the member state?
- Yes
- Yes
- No
- Not keen to answer

### Does your country have a standardised surveillance programme for HAIs?
- Yes
- Yes
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- Not keen to answer

### Are statistics on adverse events published?
- Yes
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- Not keen to answer

### Does each hospital or healthcare facility have a dedicated person responsible for patient safety?
- No
- Yes
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- Not keen to answer

### Is patient safety incorporated into the curricula for:

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  - Don't know
  - Not keen to answer

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  - Not keen to answer

- **Carers**
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### Is continuous training provided to hospital or healthcare facility staff on how to effectively combat HAIs and adverse events?
- No
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**In your opinion, which are the best tools and provisions to address patient safety at EU level?**

- **Non-binding legislation**
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- **Binding legislation**
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  - Don’t know
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- **Decree/regulation**
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  - Don’t know
  - Not keen to answer

- **Awareness raising campaign**
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  - Don’t know
  - Not keen to answer

- **Publications**
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  - Not keen to answer

- **Joint initiatives (i.e. Joint Action on patient safety)**
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### References

- Patient safety policy in Italy
- Anti-microbial resistance in Italy
- Patient Safety and HAIs in Italy
- Upcoming Italian AMR action plan
- Protocol for the monitoring of 'Sentinella events`
- Italian screening programs
- Survey on Surveillance of healthcare-associated infections in the Piemonte Region
  - http://www.simios.it/media/mrsa.pdf
- Reporting system
  - http://www.salute.gov.it/portale/ministro/p4_9_0_Lisp?lingua=italiano&categoria=Qualita_e_sicurezza_delle_cure&menu=ministeroSalute&id=114

N.B. The education and training in the field of patient safety are not covered by the national regulations and legislation. However, with the new State - Regions Agreement of 20/12/2012, the Italian Ministry of Health provides clear directives to the Regions with regard to the presence of training plans in the field of patient safety.
## ANNEX II

Research outcome

### SPAIN

<table>
<thead>
<tr>
<th>Name of the association</th>
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</tr>
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<tbody>
<tr>
<td>FECMA</td>
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<td></td>
<td></td>
</tr>
<tr>
<td>Yes</td>
<td>Yes</td>
<td>Yes</td>
<td>Yes</td>
</tr>
</tbody>
</table>

| Is the member state a part of the HAI-net (ECDC)? | Yes | Yes | Yes | Yes |

| On a scale of 1-10 (1 being not important, and 10 being very important), what level of importance does your organisation give to the issue of patient safety and healthcare associated infections (HAIs) | 10 | 7 | 10 |

| Does the member state have a national policy on: | Yes | Yes | Yes | Yes |
| Patient safety? | Yes | Yes | No | Yes |
| HAI? | Yes | Yes | No | Yes |
| Antimicrobial resistance? | Yes | Don't know | No | Yes |
| Multi-drug resistance organisms (MDRO) | Yes | Don't know | No | Yes |

| Is there a standardised screening programme for HAIs in the member state? | Yes | Don't know | Don't know | Yes |

| Does your country have a standardised surveillance programme for HAIs? | Yes | Don't know | Don't know | Yes |

| Are statistics on adverse events published? | Yes | Don't know | Don't know | Yes |

| Does each hospital or healthcare facility have a dedicated person responsible for patient safety? | No | No | Don't know | Yes |

| Is patient safety incorporated into the curricula for: | No | Yes | Yes | Yes |
| Doctors | No | Yes | Yes | Yes |
| Nurses | No | Yes | Yes | No |
| Carers | No | No | No | No |

| Is continuous training provided to hospital or healthcare facility staff on how to effectively combat HAIs and adverse events? | No | Don't know | Yes | Yes |

| Are patients proactively involved into awareness trainings on HAIs, AMR and adverse events? | No | No | Yes | Yes |

| Are the use of processes and technologies that improve efficiency and cost-effectiveness in patient safety incentivized by reimbursement structures? | No | Don't know | Don't know | Yes |

| Use of existing material: | Yes | Yes | Yes | Yes |
| Is the WHO surgical safety checklist used at national level? | Yes | Yes | Yes | Yes |
| Was the WHO save lives: clean your hands campaign promoted nationally? | Yes | Yes | Yes | Yes |
| Have the WHO guidelines on hand hygiene in health care been implemented? | Yes | Yes | Yes | Yes |
## SPAIN

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### Has the member state set a reduction rate target for:

- **CPE**
  - Yes
  - No
  - No
  - Yes
- **Infections caused by other MDRO (eg. Gramnegatives, TB, ...)**
  - Yes
  - No
  - No
  - Yes
- **Surgical Site Infections**
  - Yes
  - No
  - Yes
  - Yes
- **HAIs in intensive care units**
  - Yes
  - No
  - Yes
  - Yes
- **HAIs in long term facilities**
  - Yes
  - No
  - Yes
  - No
- **Clostridium difficile infections**
  - Yes
  - No
  - Yes
  - Yes
- **MRSA infections**
  - Yes
  - Yes
  - Yes
  - Yes

### Is there a mandatory mechanism in place for reporting of incidents for:

- **Professionals?**
  - Yes
  - Yes
  - Yes
  - No
- **Patients?**
  - Yes
  - No
  - No
  - No

### Does your country have a standardised surveillance programme for HAIs?

- Yes
  - Don’t know
  - Don’t know
  - Yes

### Are statistics on adverse events published?

- Yes
  - Don’t know
  - Don’t know
  - Yes

### Does each hospital or healthcare facility have a dedicated person responsible for patient safety?

- No
  - No
  - Don’t know
  - Yes

### Is patient safety incorporated into the curricula for:

- **Doctors**
  - No
  - Yes
  - Yes
  - Yes
- **Nurses**
  - No
  - Yes
  - Yes
  - No
- **Carers**
  - No
  - No
  - No
  - No

### Is continuous training provided to hospital or healthcare facility staff on how to effectively combat HAIs and adverse events?

- No
  - Don’t know
  - Yes
  - Yes

### Are patients proactively involved into awareness trainings on HAIs, AMR and adverse events?

- No
  - No
  - Yes
  - Yes

### Are the use of processes and technologies that improve efficiency and cost-effectiveness in patient safety incentivized by reimbursement structures?

- No
  - Don’t know
  - Don’t know
  - Yes
In your opinion, which are the best tools and provisions to address patient safety at EU level?

- **Non-binding legislation**
  - Don’t know
  - No
  - No

- **Binding legislation**
  - Don’t know
  - No
  - No

- **Decree/regulation**
  - Don’t know
  - Yes
  - Yes

- **Awareness raising campaign**
  - Don’t know
  - Yes
  - Yes

- **Publications**
  - Don’t know
  - Yes
  - No

- **Joint initiatives (i.e. Joint Action on patient safety)**
  - Don’t know
  - Yes
  - Yes

In your opinion, which are the best tools and provisions to address patient safety at national level?

- **Non-binding legislation**
  - No
  - No
  - No

- **Binding legislation**
  - Yes
  - No
  - No

- **Decree/regulation**
  - Yes
  - Yes
  - Yes

- **Awareness raising campaign**
  - Yes
  - Yes
  - Yes

- **Publications**
  - No
  - No
  - No

- **Joint initiatives (i.e. Joint Action on patient safety)**
  - Yes
  - Yes
  - No

**References**

- [Strategy for Patient Safety 2015-2020](#)
- [National Plan of Quality for the Spanish Health System](#)
- [Patient safety in Spain](#)
- [Strategic plan to reduce the risk and selection and dissemination and MDRO](#)
- [A national action plan to contain the problem of AMR has been produced](#)
- [Study of Prevalence of HAI in Spain](#)
- [Plan for screening and surveillance of HAIs: Galicia](#)
- [Guide to prevent HAIs](#)
- [WHO Save Lives: Clean your hands campaign has been promoted nationally since 2009](#)
- [Surgical suite - Standards and Recommendations](#)
- [2015-2020 Strategy for Patient Safety](#)
- [Sistemas de registro y notificación de incidentes y eventos adversos](#)
- [EPINE study. The results for 2015 can be seen here](#)
ANNEX II

Research outcome

NETHERLANDS

<table>
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<td>Yes</td>
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</table>

On a scale of 1-10 (1 being not important, and 10 being very important), what level of importance does your organisation give to the issue of patient safety and healthcare associated infections (HAIs)

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</thead>
</table>

Does the member state have a national policy on:

- Patient safety?
  - Yes
- HAIs?
  - Yes
- Antimicrobial resistance?
  - Yes
- Multi-drug resistance organisms (MDRO)
  - Yes

Is there a standardised screening programme for HAIs in the member state?

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<thead>
<tr>
<th></th>
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<th>Yes</th>
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</thead>
</table>

Does your country have a standardised screening programme for the following micro-organisms?

- Clostridium difficile
  - Yes
- Methicillin-resistant staphylococcus aureus (MRSA)
  - Yes
- Methicillin-sensitive staphylococcus aureus (MSSA)
  - Yes
- Carbapenemaseproducing enterobacteriaceae (CPE)
  - Yes

Use of existing material:

- Is the WHO surgical safety checklist used at national level?
  - No
- Was the WHO save lives: clean your hands campaign promoted nationally?
  - No
- Have the WHO guidelines on hand hygiene in health care been implemented?
  - Yes
# NETHERLANDS

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</table>

Has the member state set a reduction rate target for:
- CPE
- Infections caused by other MDRO (eg. Gramnegatives, TB, ...)
- Surgical Site Infections
- HAIs in intensive care units
- HAIs in long term facilities
- Clostridium difficile infections
- MRSA infections

<table>
<thead>
<tr>
<th></th>
<th>Yes</th>
<th>No</th>
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<tbody>
<tr>
<td>CPE</td>
<td>Yes</td>
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<td>Yes</td>
</tr>
<tr>
<td>Infections caused by other MDRO (eg. Gramnegatives, TB, ...)</td>
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<td>No</td>
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<tr>
<td>Surgical Site Infections</td>
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<td>Yes</td>
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<td>No</td>
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<tr>
<td>Clostridium difficile infections</td>
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<td>No</td>
<td>Yes</td>
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<tr>
<td>MRSA infections</td>
<td>Yes</td>
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Is there a mandatory mechanism in place for reporting of incidents for:
- Professionals?
- Patients?

<table>
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<tbody>
<tr>
<td>Professionals?</td>
<td>Yes</td>
<td>No</td>
</tr>
<tr>
<td>Patients?</td>
<td>Yes</td>
<td>No</td>
</tr>
</tbody>
</table>

Does your country have a standardised surveillance programme for HAIs?
Are statistics on adverse events published?
Does each hospital or healthcare facility have a dedicated person responsible for patient safety?

<table>
<thead>
<tr>
<th></th>
<th>Yes</th>
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</thead>
<tbody>
<tr>
<td>Standardised surveillance programme for HAIs</td>
<td>Yes</td>
<td>Yes</td>
</tr>
<tr>
<td>Statistics on adverse events published</td>
<td>No</td>
<td>Yes</td>
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<tr>
<td>Dedicated person responsible for patient safety</td>
<td>Yes</td>
<td>Yes</td>
</tr>
</tbody>
</table>

Is patient safety incorporated into the curricula for:
- Doctors
- Nurses
- Carers

<table>
<thead>
<tr>
<th></th>
<th>No</th>
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</tr>
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<tbody>
<tr>
<td>Doctors</td>
<td>No</td>
<td>Yes</td>
</tr>
<tr>
<td>Nurses</td>
<td>No</td>
<td>Yes</td>
</tr>
<tr>
<td>Carers</td>
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Is continuous training provided to hospital or healthcare facility staff on how to effectively combat HAIs and adverse events?
Are patients proactively involved into awareness trainings on HAIs, AMR and adverse events?
Are the use of processes and technologies that improve efficiency and cost-effectiveness in patient safety incentivized by reimbursement structures?

<table>
<thead>
<tr>
<th></th>
<th>No</th>
<th>Don’t know</th>
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</thead>
<tbody>
<tr>
<td>Continuous training</td>
<td>No</td>
<td>Don’t know</td>
<td>Yes</td>
</tr>
<tr>
<td>Proactive patients involvement in training</td>
<td>No</td>
<td>Don’t know</td>
<td>Don’t know</td>
</tr>
<tr>
<td>Efficiency and cost-effectiveness incentivized</td>
<td>No</td>
<td>Don’t know</td>
<td>No</td>
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</tbody>
</table>
In your opinion, which are the best tools and provisions to address patient safety at EU level?

<table>
<thead>
<tr>
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</table>

- Non-binding legislation: Yes, No
- Binding legislation: No, No
- Decree/regulation: No, No
- Awareness raising campaign: Yes, No
- Publications: Yes, No
- Joint initiatives (i.e. Joint Action on patient safety): Yes, Yes

In your opinion, which are the best tools and provisions to address patient safety at national level?

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- Awareness raising campaign: Yes, Yes
- Publications: Yes, Yes
- Joint initiatives (i.e. Joint Action on patient safety): Yes, Yes

References

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https://www.volksgezondheidenzorg.info/onderwerp/zorginfecties/preventie-zorg/preventie#node-preventieprogrammas-voor-zorginfecties
http://www.rivm.nl/Nederlanden/A/Antibioticaresistentie
http://www.rivm.nl/Documenten_en_publicaties/Professioneel_Praktisch/Richtlijnen/Infectieziekten/WIP_Richtlijnen/Actuele_WIP_Richtlijnen
National action plan also covering AMR
http://www.rivm.nl/Nederlanden/P/PREZIES
Dutch hospitals and the SURPASS-checklist
http://www.who.int/gpsc/national_campaigns/CleanHandsNet_May2013_large.png?ua=1
http://www.rivm.nl/dsresource?objectid=rivmp:260531&type=org&disposition=inline&ns_nc=1
http://www.vmszorg.nl/themas/powi/
http://igz.nl/melden/index.aspx
https://www.landelijkmelpuntzorg.nl/burger/home
http://www.volksgezondheidenzorg.info/onderwerp/zorginfecties/cijfers-context/incidentie-en-prevalentie#node-preventieprogrammas-voor-zorginfecties
http://www.nvz-ziekenhuizen.nl/
The VUMC has developed a curriculum on patient safety
High risk patients (e.g.: Clostridium difficile situations) are instructed on hygiene
ANNEX II

Research outcome

The UNITED KINGDOM

<table>
<thead>
<tr>
<th>Question</th>
<th>Desk research</th>
<th>Survey answers from IAPO</th>
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<tbody>
<tr>
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<td>Yes</td>
<td>Yes</td>
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<td></td>
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<td>Does the member state have a national policy on:</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>- Patient safety?</td>
<td>Yes</td>
<td>Yes</td>
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</tr>
<tr>
<td>- HAIs?</td>
<td>Yes</td>
<td>Yes</td>
<td>Not keet to answer</td>
</tr>
<tr>
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<td>Yes</td>
<td>Yes</td>
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In your opinion, which are the best tools and provisions to address patient safety at EU level?

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- Decree/regulation
- Awareness raising campaign
- Publications
- Joint initiatives (i.e. Joint Action on patient safety)

In your opinion, which are the best tools and provisions to address patient safety at national level?

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References

- Information from Scotland
- Information from Wales
- Information on Patient Safety across UK
- https://www.gov.uk/government/publications/the-uk-your-partner-for-patient-safety/the-uk-your-partner-for-patient-safety
- Information on HAI
- Information on AMR
- PHE launches toolkit to manage hospital infections caused by antibiotic-resistant bacteria
- Analysis of UK long term care market
- A national action plan to contain the problem of AMR and promote the prudent use of antimicrobial agents
- Health care associated infection operational guidance and standards for health protection units
- National Evidence-Based Guidelines for Preventing Healthcare-Associated Infections in NHS Hospitals in England
- Information on Hand hygiene
- Information on Surgical site infections
- http://www.gmc-uk.org/First_do_no_harm_patient_safety_in_undergrad_education_FINAL.pdf
- 62483215.pdf
- European Antibiotic Awareness Day and World Antibiotic Awareness Week