REACTION FROM LATVIA:

Dear Sir/Madam,
The Health Inspectorate of Latvia prepared information related to the questions posed by EPSO:
1. We are interested in how your country classifies/defines safety incidents. Is there a scale from most serious to least serious? Is there differentiation between preventable errors and non-preventable errors?
2. Do you cascade safety guidance from central bodies to hospitals? If so, how do you ensure compliance with it and what are the consequences if services don't comply?
3. How many safety incidents do you have each year and has this gone up or down in recent years?
4. What they do when a safety incident occurs/ what is the expectation on hospitals? Is a root cause analysis completed, is there a central reporting requirement etc.

Regulations Regarding Mandatory Requirements for Medical Treatment Institutions and Their Structural Units
Regulations of the Cabinet of Ministers No.60 Paragraph 17 of *the Regulations of the Cabinet of Ministers No. 60* "*Minimum requirements for the medical institutions and their units"* establishes requirements for providing high-quality and safe medical services to patients (requirements apply from 01.10.2017). This requirement includes the establishment and maintenance of patient safety reporting and learning system in health care institutions to ensure the collection and analysis of information on patient safety incidents. It is foreseen that the medical staff will provide information in written or electronic format about events related to patient safety.

Currently, there is no centralized system for reporting *events regarding patient safety in Latvia.*
The Center for Disease Prevention and Control of Latvia (henceforth – Center) provides a methodological support to healthcare institutions in terms of quality and patient safety. The Center has set up a working group and organized a series of discussions on the implementation of quality and patient safety requirements in practice. As a result, recommendations were developed to assist all healthcare institutions in the implementation of patient safety requirements, and the training of healthcare staff in patient safety issues will continue under the European Social Fund programs.
The developed recommendations foresee patient safety events divided into two groups:

- adverse events - events in which the patient has suffered harm (consequences had occurred), *separately allocated to* separately distributing sentinel events or never events;

- close call, near miss or potentially adverse event - an event or situation that potentially could have caused an accident, that did not occur due to random or intermittent intervention (an *error* occurred, but no damage had been made); *separately is distributed in* separately distributing safety incident - event in which mistake was almost made that could have caused damage.

The recommendations indicate that an analysis of a patient safety event in a health care institution is organized by the head of the relevant structural unit or, on his behalf, by the

person responsible for the analysis of the incident, based on the principle that the events should be evaluated by experts in the field and at the place where the safety incident occurred.
Health care institutions are recommended to use:

- The method for analyzing the course of the event - "what was done well and what was not good at the time of the incident?"

- The method of sequential analysis - the method *of analysis of* linear causes and their relevance, for example, the "why" method - a series of sequential questions "why and in what way it occurred?" and (or) "why the protective mechanisms did not work?" where each answer is a cause in series of causes, which explains the previous one.

- The method of analyzing the factors contributing to the event, thinking about how to mitigate their impact.

An analysis of the incident is concluded with conclusions and recommendations for future action to be monitored.
The patient-safety incident reporting-learning system has been implemented and maintained at the Children's Clinical University Hospital. The Health Inspectorate of Latvia does not currently have information on the annual number of registered cases in the particular hospital.
Information about the patient safety-related events, the Health Inspectorate partly has received by patients and their authorized persons applications on the quality of healthcare and indemnification of Medical Treatment Risk Fund (receipt of compensation for the damage caused to life or health of healthcare services out of court proceedings).
Over the past three years, the number of applications has increased in the framework of the Medical Treatment Risk Fund: 152 in 2015, the damage was detected in 61 cases; In 2016 - 213, damage was detected in 55 cases; In 2017 - 165, damage was detected in 51 cases.
When receiving Medical Treatment Risk Funds application, the Health Inspectorate is entitled to request the healthcare institution to estimate the case and provide the Health Inspectorate with an opinion on the existence or absence of damage and the extent of the damage. However, the regulatory framework does not define if healthcare institutions in such cases should provide information on the analysis of the incident, their conclusions or recommendations to medical practitioners for further action.

Best wishes

Alla Nogotkova
Planning, Analysis and Project Management Division
Health Inspectorate Republic of Latvia