Target-based health governance

Federal government • Federal states • Social insurance institutions

Patient safety strategy 3.0

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Summary

Background

With its commitment to ensuring and improving quality across the board in its national healthcare system by incorporating patient safety into the Health Quality Act, Austria took the initiative in 2004 to enshrine this important aspect of a safe healthcare system in law. Under this legal framework, the first quality strategy for the Austrian healthcare system was developed and subsequently adopted in 2010. The 2013 Federal Target-Based Governance Agreement defined patient safety and strengthening the health literacy of the general public as two of its strategic objectives. Based on this, the first patient safety strategy was drawn up for the Austrian healthcare system in 2013. An updated version of the quality strategy (v2.0) was published in 2017. The existing patient safety strategy was updated in parallel and presented to the public as nationwide framework specifications for the healthcare system in 2018.

The 2024–2028 Target-Based Governance Agreement stipulates that work on the quality strategy should be continued based on the specifications of the new target-based health governance period. In parallel, the Federal Ministry of Labour, Social Affairs, Health, Care and Consumer Protection commissioned the reworking of the patient safety strategy.

Methodology and structure

A **broad participatory process** was chosen as an appropriate method for reworking the patient safety strategy. Priority areas and recommendations for action were selected and ranked by the Advisory Board for Patient Safety, which had been set up for the first patient safety strategy, plus additional invited experts. The contents were developed and discussed in two workshops before being agreed upon jointly and consensually.

In addition to the vision and goals, guiding principles for implementation are presented in the patient safety strategy, as are the five priority areas for 2025 to 2029 including recommendations for action.

Patient safety strategy – priority areas with recommendations for action

Priority area 1

Transparency, openness and a no-blame culture

- Personal responsibility and health literacy
- Patient safety issues in employee appraisals/target agreements for managers
- Morbidity and mortality conferences
- Patient safety officers in facilities/departments
- Ombudsman's office for employees in healthcare facilities

Priority area 2

Patient safety in initial/continuing education and CPD

- Core competences in patient safety for healthcare professionals
- Interprofessional learning approach in initial/continuing education and CPD programmes
- Training courses for those with management and leadership responsibilities
- Assessments of employees' core competences in patient safety and requiring evidence of such competences in applications for management positions
- Initial/continuing education and CPD courses on preventing infection and combating antibiotic resistance

Priority area 3

Reporting and learning systems for patient safety incidents

- Reporting and learning systems, raising awareness amongst employees in the healthcare system as well as amongst patients
- Legally binding reporting and learning systems in the healthcare system
- Non-anonymous legally binding reports to the Federal Office for Safety in Health Care (BASG) on adverse drug reactions
- Structures and processes for error prevention based on reports

Priority area 4

Patient safety at interfaces and transitions of care

- Integrated care including the promotion of new technologies and inclusion of patient experiences
- Standardized cross-sectoral documentation
- Safety-related information on medicines and medical devices at the point of care
- Diagnosis and treatment pathways across care levels
- Safe and inclusive healthcare for vulnerable groups

Priority area 5

Learning from patients' experiences with the healthcare system

- A culture that takes the experiences of patients and their relatives into account
- Low-threshold (multilingual) feedback options
- Strengthening the competences of healthcare professionals to specifically involve patients, their relatives and representatives
- Structured procedures and platforms to facilitate exchange between those affected and healthcare services

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Abbreviations

BASG	Federal Office for Safety in Health Care (Bundesamt für Sicherheit im Gesundheitswesen)
BGK	Federal Health Commission (Bundesgesundheitskommission)
BIQG	Austrian National Institute for Quality in Health Care (Bundesinstitut für Qualität im Gesundheitswesen)
BMASGK	Federal Ministry of Labour, Social Affairs, Health and Consumer Protection (Bundesministerium für Arbeit, Soziales, Gesundheit und Konsumentenschutz)
BMGF	Federal Ministry of Health and Women's Affairs (Bundesministerium für Gesundheit und Frauen)
BMSGPK	Federal Ministry of Social Affairs, Health, Care and Consumer Protection (Bundesministerium für Soziales, Gesundheit, Pflege und Konsumentenschutz)
B-ZV	Federal Target-Based Governance Agreement/target-based health governance (Bundes-Zielsteuerungsvertrag/Zielsteuerung-Gesundheit)
CIRS	critical incident reporting system
CPD	continuing professional development
CRM	crew resource management
ELGA	electronic health record
GmbH	limited liability company
GQG	Health Quality Act (Gesundheitsqualitätsgesetz)
MTD-Austria	umbrella organization for senior medical, therapeutic and diagnostic health professions in Austria
WHO	World Health Organization

1 Introduction

The Austrian strategy for strengthening patient safety sets target specifications and provides guidance for all stakeholders in the healthcare system.

Every person has the right to safe, guideline-compliant and high-quality care when they need it. However, human behaviour and teamwork do not always go as planned or as they should.

In order to support the activities already taking place in many areas to continuously improve the safety of care and treatment, a separate nationwide patient safety strategy was developed.

The OECD's report on "The economics of patient safety: From analysis to action" (OECD 2022) identifies the consequences of unsafe treatment:

Over 1 in 10 patients is affected by adverse events during their care.

Approximately half of the safety lapses that result in harm are preventable.

Measures to prevent harm can lead to considerable savings and better outcomes.

International definitions of patient safety either focus increasingly on preventing harm and reducing risks or on identifying errors, taking an interdisciplinary approach in the event of an error and improving quality as a consequence of adverse events.

The Council of the European Union (Council of the European Union 2009) describes patient safety in more general terms as "freedom, for a patient, from unnecessary harm or potential harm associated with healthcare".

In the WHO's Global Patient Safety Action Plan 2021–2030 (WHO 2021), patient safety is defined as follows: "Today, patient harm due to unsafe care is a large and growing global public health challenge and is one of the leading causes of death and disability worldwide. Most of this patient harm is avoidable."

Going beyond these definitions, all healthcare systems face similar challenges in doing their best to ensure patient safety, regardless of the regional characteristics of the country in question or the economic situation in which the system is embedded. This concerns, for example, providing enough doctors, nursing staff and other healthcare professionals in enough healthcare facilities, managing and monitoring hospital infections and antibiotic resistance, dealing with communication and coordination problems between members of different healthcare professions and patients, addressing the lack of standardized processes and safety protocols or non-compliance with existing ones, tackling barriers to structured learning from errors and ensuring medication safety.

With its commitment to ensuring and improving quality across the board in its national healthcare system by incorporating patient safety into the Health Quality Act, Austria took the initiative in 2004 to enshrine this important aspect of a safe healthcare system in law. Under this legal framework, the first quality strategy for the Austrian healthcare system was developed and adopted (BGK 2010). The Federal Target-Based Governance Agreement (B-ZV 2013) then

enshrined patient safety and strengthening the health literacy of the general public, as two of its strategic objectives. Based on this, the first patient safety strategy was drawn up for the Austrian healthcare system (BMG 2013).

An updated version (v2.0) of the quality strategy was published in 2017 (BMGF 2017).[1] The existing patient safety strategy was updated in parallel and published in 2018 as nationwide framework specifications for the Austrian healthcare system (BMASGK 2018) with the goal of continuously improving the quality of healthcare and patient safety as well as specifying a framework for safe care. As in the first patient safety strategy, it mainly addressed those funding the healthcare system as well as its facilities, healthcare professionals and patients.

On the international stage, the WHO's Global Patient Safety Action Plan 2021–2030 (WHO 2021) was adopted and published as one of the most important international strategy papers at the 74th World Health Assembly. This plan calls for patient safety to be seen as a global health priority and as "an essential component for strengthening health care systems".

The WHO's global action plan was one of the most important guidance documents for developing this version (v3.0) of the patient safety strategy for Austria.

The aspirations of the WHO's global action plan are also reflected in the current Target-Based Governance Agreement (2024–2028). In Article 2(7) on health policy principles and objectives, it states that "quality work should be comprehensively and bindingly anchored on all levels of the healthcare system in order to increase effectiveness and efficiency as well as to improve patient safety in accordance with the WHO's international patient safety goals".

Alongside v3.0 of the patient safety strategy, the third quality strategy (BMASGPK 2025) was also drawn up for the Austrian healthcare system. The quality strategy should lay the foundations for coordinating and pooling quality activities in all sectors. In addition to continuously improving the quality of care and services, all efforts and measures in the quality strategy focus on the safety of patients and employees as well as digitalization and increased cooperation between service providers as its overarching goals.

The quality strategy and patient safety strategy are essential documents for guiding and planning improvement processes in the healthcare system. They pursue different yet closely related goals. While the quality strategy aims to continuously improve care and increase the efficiency of the system, the patient safety strategy focuses specially on reducing risks or preventing harm as well as on continuously learning from experience to prevent errors. A separate patient safety strategy was commissioned so as to target priority areas and recommendations for action that go beyond general improvements in quality. These should not only contribute to protecting patients but also to improving trust in the healthcare system.

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[1] With the extension of the Agreement pursuant to Article 15a of the Federal Constitutional Act on the Organization and Financing of the Healthcare System (B-VG über die Organisation und Finanzierung des Gesundheitswesens) as well as the Agreement pursuant to Article 15a of the Federal Constitutional Act on Target-Based Health Governance (B-VG Zielsteuerung-Gesundheit) for 2022 and 2023, the quality strategy was also extended by two years as version 2.1.

2 Vision and goals

Working together to provide safe healthcare: learning, trust and responsibility

Statement issued by the Advisory Board for Patient Safety:[2]

> "We wish to shape a healthcare system in which patient safety can be taken for granted – supported by an open, learning, responsible culture.
>
> Our **vision** is a system in which errors are not hidden but understood and addressed, in which employees can speak without fear of being blamed and in which lessons are learned together from experience to prevent harm.
>
> Our **goal** is to create trustful, resilient and learning organizations in which patient safety is not just a goal but a lived value – on a daily basis and at all levels."

In practice, safety culture means that:

- safety awareness is firmly anchored in every decision, in every process, in every role on a day-to-day basis;
- employees are actively empowered to identify risks, address them openly and initiate improvements;
- learning from critical incidents takes place systematically thanks to transparent analyses, feedback and structural changes;
- managers prioritize safety over efficiency and act as role models for trust and willingness to learn;
- patients and their relatives are taken seriously and involved as partners in the safety dialogue.

Thanks to their experience, well qualified, highly competent, committed and satisfied employees create the foundations for a safe healthcare system. Employees are fully committed to their work when they know that their actions are valued and their assessment of situations is heard or that processes are optimized when they report anomalies or inconsistencies to the appropriate authority in their work environment. Thanks to their work, satisfied and committed employees make a continuous contribution to reducing the number of adverse events and improving clinical treatment.

Patients play an important role as key members in the treatment process and should be able to participate actively. Their experiences are valued and contribute specifically to improving the healthcare system on an ongoing basis. This strengthens trust in the system. One prerequisite for this is well-developed health literacy.

If an adverse event occurs, support is provided to affected patients and staff on a human-to-human psychological level as well as on an objective, professional level.

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[2] The Advisory Board for Patient Safety advises the Federal Minister of Health on issues in this area, see www.sozialministerium.at/Themen/Gesundheit/Gesundheitssystem/Gesundheitssystem-und-Qualitaetssicherung/Patient-innensicherheit-und-Patient-inneninformationen/Beirat-fuer-Patientinnen--und-Patientensicherheit.html [accessed on 09.07.2025].

3 Methodology

A broad participatory process was chosen for developing and reworking the patient safety strategy. Priority areas and recommendations for action were selected and ranked by the Advisory Board for Patient Safety and additional invited experts. The contents were developed and discussed in two workshops before being agreed upon jointly and consensually. The preparation process, the workshops and the drafting of the strategy were organized and supported by the Austrian National Public Health Institute (GÖG).

The contents of the patient safety strategy were based on:

- preliminary work on updating the patient safety strategy 2.0 (Geißler 2023);
- the Global Patient Safety Action Plan 2021–2030: Towards eliminating avoidable harm in health care. World Health Organization, Geneva (WHO 2021);
- the results of surveys conducted as part of the quality symposium organized by the Federal Ministry of Social Affairs, Health, Care and Consumer Protection, the 1st Tyrolean quality symposium held in Innsbruck and the conference on biomedical analytics in Vienna, all held in 2024.

The priority areas and recommendations for action were developed and agreed upon in two workshops.

Representatives of the following were involved:

- the Advisory Board for Patient Safety plus representatives from the Patient Advocates Working Group, the Federal Ministry of Labour, Social Affairs, Health, Care and Consumer Protection, the Federal Chamber of Labour, the federal states, the Austrian Self-Help Association, the Umbrella Organization for Self-Help in Lower Austria, the Federation of Austrian Social Insurances, the Austrian National Public Health Institute (GÖG), hospitals, the National Self-Help Network, the Austrian Agency for Health and Food Safety, the Austrian Chamber of Pharmacists, the Austrian Medical Chamber (for hospital-based and self-employed doctors), the Austrian Health Insurance Fund, the Austrian Network for Patient Safety and the Austrian Chamber of Commerce;
- two professional associations (the Austrian Health and Nursing Association and MTD-Austria).

Nineteen people took part in the first workshop and 24 in the second; both workshops lasted for four hours. The priority areas and recommendations for action were developed in small groups and then discussed and agreed upon by all participants.

After each workshop, the texts for the strategy, which were based on the groundwork laid at the meeting, were sent out, feedback was collected and incorporated, the representatives were informed of the changes and the text was finalized.

Decisions on the patient safety strategy were coordinated in the following committees:

- the Advisory Board for Patient Safety plus representatives of two professional associations (the Austrian Health and Nursing Association and MTD-Austria);
- the expert group on care processes/working group on quality;
- the Quality Council.

The patient safety strategy was approved and adopted by:

- the Standing Coordination Committee (committee for target-based health governance).

4 Guiding principles for implementation

The safety of healthcare is upheld by established safe processes with the help of everybody working in the healthcare system and taking account of the experiences of anybody affected by safety issues. International research and experience reveal that key requirements must be met to ensure the safety of healthcare.

As a strategic document, the patient safety strategy defines important **priority areas** for the next few years that should receive increased attention and be addressed even more intensively. The recommendations for action in these priority areas directly address various stakeholders, including healthcare facilities and their management, those responsible for quality and risk management, everybody working in the healthcare system and patients. In areas where a general framework needs to be created, such responsibilities lie with the federal government, federal states and social insurance institutions.

A living **safety culture** in a facility that provides an appreciative and learning environment contributes significantly to the faster and better establishment of safe measures and procedures. In this context, managers in a facility play an essential role in promoting and implementing this culture. That is why the priority areas and recommendations for action in this patient safety strategy relate particularly to issues of safety culture.

5 Priority areas for 2025–2030

In the 2024–2028 Target-Based Governance Agreement (Zielsteuerung-Gesundheit 2024), the federal government, federal states and social insurance institutions agreed on health policy principles and goals. In Article 2(7) a joint declaration was made that "quality work should be comprehensively and bindingly anchored on all levels of the healthcare system in order to increase effectiveness and efficiency as well as to improve patient safety in accordance with the WHO's international patient safety goals".

The current patient safety strategy was redrafted on the basis of the WHO's priority areas and recommendations for action (WHO 2021) together with the Advisory Board for Patient Safety[3] and additional experts from the Austrian Health and Nursing Association and MTD-Austria in order to boost the safety of healthcare for patients in Austria. This is to be achieved by focusing on five priority areas in all. The procedure for preparing the strategy is described in more detail in Chapter **Fehler! Verweisquelle konnte nicht gefunden werden.**.

The **priority areas** in this patient safety strategy and the resulting **recommendations for action** are addressed to patients and their relatives as well as decision makers, facilities and everybody working in the healthcare system.

5.1 Transparency, openness and a no-blame culture

A strong safety culture is a key component in a productive healthcare system and must be firmly integrated into its structures and values. Healthcare facilities can pursue different strategies to strengthen patient safety but certain basic principles are indispensable:

- active and strong support from the top
- transparency on all levels
- open and respectful communication
- learning from errors.

In this context, a balance must be found between individual responsibility and a systemic approach to preventing errors. Patients have the right to know when an adverse event has occurred. Treating those affected with respect is a prerequisite for an open error culture; this includes explaining the event and the ensuing course of action. In addition, information should be provided on how the facility will learn from the event and which preventive measures will be taken to avoid adverse events in the future. It should also be a matter of course that, in the event of an error, support is not only provided to patients but also to employees who were directly affected by the adverse event (second victims).

[3] Cf. www.sozialministerium.at/ [accessed on 09.07.2025].

Rationale

Only an open approach to critical incidents and adverse events, without fear of consequences creates an environment in which learning can take place in the best possible way.

Operational objective 1

Establishing transparency, openness and a no-blame culture

1.1 Strengthening personal responsibility and health literacy and raising the general public's awareness of best practice examples (if interested)

1.2 Anchoring patient safety issues in employee appraisals/target agreements for managers

1.3 Initiating morbidity and mortality conferences in hospitals incl. audits

1.4 Anchoring patient safety officers in facilities/departments

1.5 Setting up an ombudsman's office for employees in healthcare facilities

Recommendations for action

1.1 Strengthening personal responsibility and health literacy and raising the general public's awareness of best practice examples (if interested)

Responsibility of: federal government, the Austrian Network for Patient Safety and other organizations

Explanation: On the one hand, personal responsibility and the health literacy of patients and the general public should be encouraged and on the other hand, a framework should also be created to foster patients' self-empowerment. This can be achieved by highlighting proven best practice examples that address these aspects (cf. measures and materials provided by the Austrian Platform for Health Literacy, www.ÖPGK.at, or the Patient Safety Award organized by the Austrian Network for Patient Safety, www.plattformpatientensicherheit.at/). Initiatives like roadshows, for example, or presenting special awards can highlight successful projects and measures to strengthen personal responsibility and health literacy and to make them accessible to a broader target group. This promotes awareness of safety aspects in the healthcare system, inspires imitation and supports the development of a sustainable safety culture.

1.2 Anchoring patient safety issues in employee appraisals/target agreements for managers

Responsibility of: federal government (statutory provisions), hospital operators

Explanation: Managers should be made aware of the relevance of patient safety and patient safety issues should be actively incorporated into strategic and operational decisions. By anchoring them in employee appraisals/target agreements, patient safety goals should be strengthened at management level and a safety culture should be promoted throughout the organization.

1.3 Initiating morbidity and mortality conferences in hospitals including audits

Responsibility of: hospital operators, hospitals

Explanation: The goal of regularly carrying out morbidity and mortality conferences, debriefings and case discussions in hospitals is to allow a systematic analysis of errors, complications and near misses. Interdisciplinary reflection and open discussions should promote a learning safety culture and inform measures for improving patient safety. Auditing these discussions ensures continuous quality assurance.

1.4 Anchoring patient safety officers in facilities/departments

Responsibility of: federal government, federal states, hospital operators, health service providers

Explanation: At management level a member of staff with the required professional background should be made responsible for patient safety, provided that the facility has contact with patients. Patient safety officers assume clear responsibilities for their tasks and must be given the necessary powers and time to do so.

The task of management is to secure resources and boost the competences of patient safety officers as well as to discuss their proposals for measures or their evaluation results. Management is responsible for ensuring that the measures are implemented; decisions not to do so must be justified. The role of a patient safety officer does not involve any liability claims, however. There is a clear demarcation of legal responsibility here. It should be possible to coordinate and implement patient safety measures in an effective manner. In the time dedicated to their duties, patient safety officers can focus specifically on analysis and prevention as well as on the improvement of safety processes, thus contributing actively to strengthening patient safety.

1.5 Setting up an ombudsman's office for employees in healthcare facilities

Responsibility of: federal government, federal states, hospital operators

Explanation: An ombudsman's office serves as a neutral point of contact in healthcare facilities for reporting complaints and concerns (e.g. about grievances, misconduct or safety issues), without fear of reprisal. The aim is to promote a safety culture and lower the threshold for reporting, thus supporting a continuous improvement in patient safety.

An ombudsman's office for employees in healthcare facilities can mediate, advise and build confidence between employees and employer using structures such as quality and risk management departments or works councils for this purpose if they already exist. It is important that the ombudsman's office is independent and neutral. In addition, specific professional, personal and ethical skills are essential for filling such a position, such as knowledge of labour and health law, mediation and conflict resolution. Psychosocial skills and organizational knowledge are also important for performing this function.

5.2 Patient safety issues in initial/continuing education and continuing professional development

The quality of healthcare and the safety of patients depend largely on the competence and skills of doctors and other healthcare professionals.

Patient safety issues should already be given greater consideration in initial education but should also be incorporated into continuing education and continuing professional development (CPD). It is not only a case of imparting theoretical knowledge; the focus should also be on learning in teams. In addition, the close connection between personal and professional health literacy and patient safety should be outlined and communicated.

Rationale

For several years now, the WHO has recommended introducing a specific curriculum for patient safety (WHO 2011) as attention should already be paid to raising awareness of the issue of safety in initial education. In this sense, a shift towards an open error culture can be promoted through appropriate qualifications in initial/continuing education and CPD.

Operational objective 2

Integrating patient safety into initial/continuing education and providing courses in CPD

2.1 Defining core competences in patient safety for healthcare professionals and integrating the goals of these core competences into initial/continuing education and CPD

2.2 Incorporating an interprofessional learning approach into initial/continuing education and CPD programmes including regular team training with a focus on crew resource management

2.3 Setting up advanced training courses on patient safety for those with management and leadership responsibilities

2.4 Regularly assessing employees' core competences in patient safety and requiring evidence of such competences in applications for management positions

2.5 Ensuring initial/continuing education and CPD courses for healthcare personnel on preventing infection and combating antibiotic resistance

2.1 Defining core competences in patient safety for healthcare professionals and integrating the goals of these core competences into initial/continuing education and CPD

Responsibility of: federal government, medical universities, universities of applied sciences, specialist training centres, hospital operators, professional associations

Explanation: Core competences should be defined for healthcare professionals that are essential for promoting patient safety in their daily work. These include communication competences, error management, interdisciplinary teamwork, professional health literacy and infection control precautions. Attainment of these core competences should be systematically integrated into initial/continuing education and CPD to ensure that all medical professionals are trained in safe, patient-centred practices at an early stage and on an ongoing basis. Training courses on patient safety should be integrated into onboarding programmes for new employees. All employees should have the necessary knowledge and competences to promote patient safety from the outset. The methodology of initial education and training courses must be planned in such a way that the learning objectives can actually be achieved (e.g. experience-based communication training to change communicative behaviour; cf. courses provided by the Austrian Platform for Health Literacy).

2.2 Incorporating an interprofessional learning approach into initial/continuing education and CPD programmes including regular team training with a focus on crew resource management

Responsibility of: hospital operators, health service providers, medical universities, universities of applied sciences

Explanation: Interprofessional learning approaches and regular team training with a focus on crew resource management promote effective communication, decision making and teamwork in stressful and complex situations. Thanks to these measures, healthcare personnel from different disciplines learn to work safely and efficiently in teams at an early stage, which improves cooperation and patient safety in the long run.

2.3 Setting up advanced training courses on patient safety for those with management and leadership responsibilities

Responsibility of: hospital operators, health service providers, training organizations

Explanation: The goal of advanced patient safety training courses for managers is to raise their awareness of safety-related issues and provide them with the necessary knowledge and practical tools to contribute actively to promoting a culture of safety. For this reason, managers should consistently assume responsibility for patient safety in their decisions and when dealing with teams.

2.4 Regularly assessing employees' core competences in patient safety and requiring evidence of such competences in applications for management positions

Responsibility of: hospital operators, health service providers, training organizations

Explanation: Employees' core competences in relation to patient safety should be assessed regularly, for example during employee appraisals. In addition, those aspiring to management positions should attend appropriate safety training courses and be specifically assessed on their patient safety skills in competence development interviews. This is intended to continuously strengthen the qualifications and awareness of all employees with regard to safety-related issues. In addition, prospective managers should have the necessary competences to actively promote a culture of safety and learning.

2.5 Ensuring initial/continuing education and CPD courses for healthcare personnel on preventing infection and combating antibiotic resistance

Responsibility of: hospital operators, health service providers, training organizations

Explanation: As part of initial/continuing education and CPD, all healthcare personnel should attend training courses on preventing infection and combating antibiotic resistance (antibiotic stewardship) in order to prevent infections as effectively as possible and ensure the responsible use of antibiotics, thus promoting patient safety. Information on preventing infection and combating antibiotic resistance should be made available to patients as part of their care.

5.3 Reporting and learning systems for patient safety incidents

Reporting and learning systems are risk management tools that can be used to identify and analyse critical incidents in order to inform measures for improvement. As long as these systems are well implemented and both accepted and used by employees, they help reduce errors continuously. The learning aspect of these systems is vital for them to be able to contribute to a positive error culture. These systems must be promoted repeatedly and, above all, actively embraced so that the effort is justified and they really bring actual benefits in terms of increasing patient safety.

Over the last 15 years, more **reporting and learning systems** have been set up in hospitals in Austria. The reports on quality systems provide information on the use of these systems (BMSGPK 2022; BMSGPK 2024a; BMSGPK 2024b; BMSGPK 2024c). In addition, the publicly accessible cross-institutional and cross-professional reporting and learning system CIRSmedical was set up by the Austrian Medical Chamber as early as 2009 and has been operated by the Austrian Society for Quality Assurance and Quality Management in Medicine (ÖQMED) ever since. The aim is to learn from reported incidents by having cases analysed and commented on by experts. Patients can also upload reports to CIRSmedical. In line with a no-blame culture, the focus is on learning.

The reporting of never events, i.e. medical errors that should never happen and that can result in serious patient harm or even death, has not yet become established in Austria. Work is currently underway with the aim of implementing such a reporting system in autumn 2025.

Rationale

The extent to which reporting and learning systems set up in individual healthcare facilities are actually used, also for extrapolating measures and for continuous learning, is not known in detail. It is important to maintain or improve the reliability of employees' reports on adverse events as reporting still does not happen as a matter of course. Managers and those responsible for such systems are, therefore, called upon to repeatedly remind employees of existing reporting and learning systems and to emphasize the benefits for the organization, their colleagues and, ultimately, for their patients.

Operational objective 3

Expanding reporting and learning systems for patient safety incidents

3.1 Promoting reporting and learning systems and raising awareness amongst employees and patients on the relevance of submitting reports, which are then reviewed

3.2 Continuing to work on and promote legally binding reporting and learning systems in the healthcare system

3.3 Establishing non-anonymous legally binding reports to the Federal Office for Safety in Health Care (BASG) on adverse drug reactions (for better tracking)

3.4 Implementing structures and processes for error prevention based on reports

Recommendations for action

3.1 Promoting reporting and learning systems and raising awareness amongst employees and patients on the relevance of submitting reports, which are then reviewed

Responsibility of: federal government, professional associations, management of facilities

Explanation: Healthcare personnel should be made aware of in-house and cross-institutional reporting and learning systems as well as get to know and use the platform for never events set up in 2025. Patients should also know about the possibility of uploading reports to CIRSmedical and should use such a system. These target groups should know which incidents can be captured in reporting and learning systems, for example in the context of diagnostics and therapy, on an organizational level (interfaces, communication) or digital services. Awareness raising should emphasize the importance of reporting adverse events for the benefit of patient safety. Analyses of reported cases should then inform measures for improvement. This will promote an open safety culture and improve the quality of care sustainably.

3.2 Continuing to work on and promote legally binding reporting and learning systems in the healthcare system

Responsibility of: federal government, professional associations, management of facilities, Federal Office for Safety in Health Care (BASG)

Explanation: Legally binding reporting and learning systems in the healthcare system (e.g. reports to the Federal Office for Safety in Health Care) serve to centrally record and evaluate safety-related incidents such as adverse drug reactions or quality defects in medical devices, blood and tissue products and, if necessary, to initiate corrective actions to prevent errors and improve quality in the healthcare system. It is currently unclear to what extent the various reporting systems are used in relation to the actual number of incidents. Experts assume, however, that the reporting rate is too low. Increased attention and awareness raising are, therefore, necessary to motivate health service providers and the general public to report incidents, with the transparency of reporting systems playing an essential role in this context. Reporting statistics should be published as well as data on the measures and steps taken in response to the reports. Additional options for refining such systems should also be investigated. For example, at present, errors or incidents that occur in the context of telemedicine or other digital applications cannot be reported in a structured manner. It should be checked whether new reporting systems are required for this purpose or whether such reports can be integrated into existing structures.

3.3 Establishing non-anonymous legally binding reports to the Federal Office for Safety in Health Care on adverse drug reactions (for better tracking)

Responsibility of: federal government, Federal Office for Safety in Health Care (BASG), professional associations, management of facilities

Explanation: Non-anonymous and legally binding reports on adverse drug reactions should be made more widely known and improved accordingly. Better tracking of such reports facilitates targeted analyses of causes and the development of preventive measures. At the same time, this transparency raises awareness amongst healthcare professionals, patients and other stakeholders concerning the importance of using medicines responsibly.

3.4 Implementing structures and processes for error prevention based on reports

Responsibility of: management of facilities, experts (e.g. CIRSmedical)

Explanation: Reports to and notifications from reporting and learning systems should be analysed systematically and used as a basis for setting up structures and processes to prevent errors. A key aspect is providing feedback on improvements resulting from the reports, both to those who submitted them and to the organization as a whole. This improves trust in the reporting processes, promotes an open error culture and ensures that patient safety is continuously improved by implementing concrete measures.

5.4 Patient safety at interfaces and transitions of care

Ensuring patient safety at interfaces and transitions of care is closely linked to good communication and the correct transfer of information. If information is inaccurate, not fully documented or does not reach the recipient, it increases the likelihood that continuity of care is lost. Incomplete or unclear information for or about patients can quickly lead to misunderstandings and errors in treatment. For example, errors can occur when updating and harmonizing medication lists, leading to incorrect dosages and/or drug-drug interactions (WHO 2011).

Rationale

Interfaces and transitions of care represent a high-risk period with the potential for errors that can be avoided by improving communication, documentation and patient involvement. Therefore, proven methods and practices should be promoted that aim to prevent errors and optimize processes at interfaces and transitions of care, thus contributing to patient safety.

Operational objective 4

Improving patient safety at interfaces and transitions of care

4.1 Expanding integrated care by promoting digitalized processes and new technologies as well as including the experiences of patients and their relatives

4.2 Ensuring standardized cross-sectoral documentation across all health service providers

4.3 Ensuring safety-related information on medicines and medical devices at the point of care

4.4 Developing and setting up diagnosis and treatment pathways across care levels

4.5 Providing safe and inclusive healthcare for vulnerable groups

4.1 Expanding integrated care by promoting digitalized processes and new technologies as well as including the experiences of patients and their relatives

Responsibility of: federal government, federal states, social insurance institutions, ELGA-GmbH, health service providers

Explanation: The expansion of integrated care should be continued by making use of digitalized processes and new technologies. Integrated information infrastructures should be set up (in ELGA) to enable seamless communication and collaboration between everybody involved in the care process. The necessary legal framework must be established or existing frameworks must be amended to cover this. In addition, the experiences of patients and their relatives must be factored in to make care practicable and tailored to their needs. This improves the coordination, efficiency and quality of care while also helping to strengthen patient safety.

4.2 Ensuring standardized cross-sectoral documentation across all health service providers

Responsibility of: federal government, federal states, social insurance institutions, ELGA-GmbH, health service providers, all healthcare professions

Explanation: Standardized cross-sectoral documentation across all health service providers should ensure timely, accurate and consistent treatment and care while supporting workflows between health service providers. Particularly in the area of medication safety (e.g. avoiding polypharmacy), standardized documentation facilitates better coordination between stakeholders, reduces the risk of errors and optimizes patient care.

4.3 Ensuring safety-related information on medicines and medical devices at the point of care

Responsibility of: federal government, federal states, social insurance institutions, ELGA-GmbH, health service providers

Explanation: Safety-related information should be made available to health service providers and patients directly at the point of care, i.e. where treatment takes place, in order to support decision making, amongst other things. This includes important information on the dosage for or adverse events associated with medicines and medical devices, for example. Health service providers need the competences to communicate information effectively. Training courses should provide practice in patient-centred communication (see, for example, courses organized by the Austrian Platform for Health Literacy.

4.4 Developing and setting up diagnosis and treatment pathways across care levels

Responsibility of: federal government, federal states, social insurance institutions, ELGA-GmbH, health service providers, professional associations, medical societies

Explanation: Clearly defined, standardized processes should speed up diagnosis, coordinate treatment and optimize referrals. Processes for patients and their relatives should be easy to understand and the necessary steps should be easy to implement. Digital and personal support systems (e.g. active reminders and follow-up questions from health service providers) and health service providers encouraging self-management should ensure that patients can follow their care pathways more easily and safely. Structured care pathways across all levels of care ensure holistic, continuous care throughout all phases of an illness and can help avoid delays in diagnosis and starting treatment as well as incorrect treatment.

4.5 Providing safe and inclusive healthcare for vulnerable groups

Responsibility of: federal government, federal states, social insurance institutions, ELGA-GmbH, health service providers, self-help groups

Explanation: Vulnerable groups (cf. https://fgoe.org/Glossar/Vulnerable_Personengruppen) are defined as groups that are more susceptible to social, economic, cultural, political or health disadvantages due to their characteristics (such as age, gender, ethnic background, socio-economic status). Patient safety plays an important role for these groups as their special needs expose them to an increased risk of limited access to medical care and health disadvantages due to inadequate or insufficient care and/or discrimination. Healthcare should, therefore, be designed to be accessible, inclusive and tailored to the specific needs of vulnerable groups. Health service providers should be trained in dealing with vulnerable groups.

5.5 Learning from patients' experiences with the healthcare system

A high level of health literacy enables citizens to navigate the healthcare system, make informed decisions and take an active role in their own medical care. This does not only include knowledge about available services and how to use them correctly but also the ability to provide feedback on experiences to appropriate authorities. It is essential that suitable instruments exist or are expanded to retrieve experiences in a structured manner and allow individuals to contribute their own experiences in the first place. This gives citizens the role of fully fledged partners in the healthcare system, enabling them to contribute to improving care and increasing the quality and safety of treatment in the long run.

Rationale

As affected parties, patients are the ones who experience the healthcare system first hand and gain a range of valuable experiences that can be used to improve the healthcare system. Currently, these experiences are not being recorded systematically or utilized to a sufficient extent.

Operational objective 5

Improving learning from patients' experiences with the healthcare system

5.1 Creating a culture in which the experiences of patients and their relatives can be taken into account

5.2 Creating, fine-tuning and publicizing low-threshold (multilingual) feedback options

5.3 Strengthening the competences of healthcare professionals to directly involve patients, their relatives and representatives

5.4 Setting up structured procedures and platforms to involve patients, citizens and their representatives to facilitate exchange between those affected and healthcare service providers

5.1 Creating a culture in which the experiences of patients and their relatives can be taken into account

Responsibility of: federal government, federal states, social insurance institutions, health service providers

Explanation: It is important to promote a culture that attaches great importance to the experiences of patients and recognizes them as a valuable resource for improving the healthcare system. In this context, patients should be encouraged to provide feedback and become aware of the fact that their feedback can make an important contribution to improving care. This can be supported, for example, by regular patient surveys that make it possible to record their experiences and needs as well as potential for improvement from their perspective. The insights gained in this way can then be incorporated into the design and optimization of processes to increase patient safety and the quality of care. It is also necessary to enable patients and the general public to participate in the design of processes in the healthcare system.

5.2 Creating, fine-tuning and publicizing low-threshold (multilingual) feedback options

Responsibility of: federal government, federal states, social insurance institutions, health service providers

Explanation: Low-threshold and multilingual feedback options should be created, fine-tuned and publicized. Patients and/or their relatives should be able to report on their experiences with the healthcare system or with health service providers in a simple, secure and accessible manner. Low-threshold access to such systems, for example, via surveys, online forms, telephone hotlines or local contact points, is vital for success. The aim should be to obtain feedback that is as comprehensive as possible. The availability of multilingual reporting channels should ensure that culturally and linguistically diverse groups are reached. In addition, individuals who submit reports should, if necessary, receive feedback on how their input has been processed and what measures, if any, have been taken as a result. This increases transparency and trust in the system. The experiences of those affected should be analysed systematically and incorporated into the improvement of structures and processes. It is essential that that an organizational framework is in place for a structured recording of patient experiences.

5.3 Strengthening the competences of healthcare professionals to directly involve patients, their relatives and representatives

Responsibility of: federal government, federal states, health service providers, training organizations

Explanation: The competences of healthcare professionals when dealing with patients, their relatives and representatives should be strengthened (professional health literacy). Through quality-assured, targeted training courses and communication training (cf. courses organized by the Austrian Platform for Health Literacy, ÖPGK), healthcare personnel should learn how to actively involve patients and the people around them in their care and how to work better in interdisciplinary teams. Training courses can teach techniques and knowledge for involving patients and their relatives as partners in decision-making processes for care and treatment as well as for incorporating their perspectives into care processes. Communication training can enhance the competences of healthcare personnel in relation to clear and understandable communication in order to improve exchange with patients and relatives and avoid misunderstandings. By promoting patient-centred dialogue between healthcare professionals, patients and their representatives, the effectiveness of information transfer and cooperation can be strengthened to make care safer.

5.4. Setting up structured procedures and platforms to involve patients, citizens and their representatives to facilitate exchange between them and healthcare personnel

Responsibility of: medical societies, self-help groups, health service providers

Explanation: Structured procedures and platforms should be set up that enable systematic exchange between patients, citizens, their representatives and healthcare personnel. The perspectives and experiences of those affected should be actively incorporated into the design and improvement of healthcare. Different methodological approaches should be used to implement them.

Both digital and physical platforms could be set up to enable continuous and low-threshold communication between healthcare personnel and those affected. Topic-specific events (workshops) could also be organized in which those affected and healthcare personnel work together to find solutions or develop suggestions for improvement. Patient advocates and citizen representatives can be invited to conventions and conferences organized by medical societies, for example, to include their insights directly in discussions on standards and strategies. Different approaches promote transparency and strengthen patient centredness.

6 Classification of recommendations for action by target group

Table 1 below shows who the recommendations for action address primarily. In other words, the table provides a more differentiated view of who should primarily benefit from the individual recommendations for action. The table does not include who is responsible for implementing the recommendations.

Table 1: Classification of recommendations for action in the patient safety strategy by target group

Strategy for improving patient safety	Target groups for the recommendations for action		
Priority areas for 2025–2030 and their operational objectives	**Patients, relatives and their advocacy groups**	**Healthcare professionals incl. management and leadership**	**Healthcare system**
Operational objective 1: Establishing transparency, openness and a no-blame culture	1.1, 1.5	1.2, 1.3, 1.4,1.5	1.1, 1.2
Operational objective 2: Integrating patient safety into initial/continuing education and CPD		2.1, 2.2, 2.3, 2.4, 2.5	2.1
Operational objective 3: Expanding reporting and learning systems for patient safety incidents	3.1, 3.3, 3.4	3.1, 3.2, 3.3, 3.4	3.2, 3.3, 3.4
Operational objective 4: Improving patient safety at interfaces and transitions of care	4.1, 4.3, 4.5	4.1, 4.2, 4.3, 4.4	4.1, 4.2, 4.3, 4.4, 4.5
Operational objective 5: Improving learning from patients' experiences with the healthcare system	5.1, 5.2, 5.4	5.1, 5.3, 5.4	5.2

Source: GÖG/BIQG

7 Measures accompanying the strategy

7.1 National coordination office in the Federal Ministry of Labour, Social Affairs, Health, Care and Consumer Protection

The Coordination Office for Patient Safety in the ministry develops and promotes initiatives and work related to patient safety with specialist expertise provided by the Advisory Board for Patient Safety. In particular, the coordination office represents and coordinates specific perspectives on patient safety in line with the goals of and committees working on target-based health governance and other relevant strategies and plans. It coordinates activities within the ministry concerned and with the necessary partners in the healthcare system.

The tasks of the national coordination office include:

- organizing and chairing the Advisory Board for Patient Safety;
- publishing an annual report on patient safety activities at federal level;
- coordinating activities related to patient safety between the Federal Ministry of Labour, Social Affairs, Health, Care and Consumer Protection, other ministries, the federal states, social insurance institutions, advocacy groups and professional associations, health service providers, the patient ombudsmen's office and patient representatives, self-help groups, etc.;
- actively representing patient safety agendas in various national and international committees.

7.2 Advisory Board for Patient Safety

In accordance with § 8 of the Federal Ministries Act (1986), the Advisory Board for Patient Safety advises the Federal Minister of Health on technical issues relating to patient safety. All key decision makers as well as patients themselves are represented on the advisory board and have voting rights.

How the advisory board works:

- advising the federal minister responsible for health
- holding regular meetings (usually twice a year)
- publishing the minutes on the ministry's website.

7.3 Publishing and presenting activities relevant to patient safety

Annual reports on patient safety should be prepared and published as before. This is done on behalf of the national coordination office in the ministry by continuously monitoring and collecting activities relevant to patient safety in all areas of the healthcare system. Transparent presentations are then prepared on the results and progress made on nationwide projects that contribute to patient safety, particularly in the relevant priority areas.

8 Glossary

Adverse event

An adverse event is any harmful medical incident that happens to a patient during or after medical treatment, such as taking medication, that is not, however, necessarily caused by that intervention. (Source: www.iqwig.de)

Crew Resource Management

Crew resource management (CRM) is a strategy to improve system-based and team safety and, consequently, patient safety. With its roots in aviation, CRM is a training programme for teams that was adapted for use in medicine. CRM focuses on cooperation, situational awareness, leadership skills and decision making as well as safe and effective communication within a team. Workload management and task allocation play an essential role here. Using and sharing all important information within a team is another core component of CRM. (Source: https://inpass.de)

Error

The failure to carry out a planned action as intended or the application of a wrong plan or no plan. An error may or may not cause an adverse event. (Source: APS, www.aps-ev.de)

Health service providers

All individuals and facilities that provide healthcare services – such as medical care, examinations, nursing care, etc. – or support patients in the exercising of their rights. The precise legal definition is given in § 2(2) of the Health Telematics Act (Gesundheitstelematikgesetz 2012). Individual health service providers are registered in the eHealth Directory Service (Verzeichnisdienst, eHVD) with an identity (OID) and one or more roles, for example as a general practitioner. (Source: www.gesundheit.gv.at)

Inclusive healthcare

The term inclusive healthcare describes a healthcare system that gives everyone equal access to care, treatment and support, regardless of individual characteristics such as disability, social status, gender or origin. Inclusive healthcare takes the special needs of different demographic groups into account and ensures that barriers are removed, for example in the form of accessible doctors' surgeries and hospitals for people with physical disabilities and easy language and sign language interpreters for people with cognitive impairments or specific communication needs as well as culturally appropriate care to take the medical needs of different demographic groups into account. (Source: definition provided by GÖG)

Integrated care

Integrated care is about patient-oriented, continuous, cross-sectoral and/or interdisciplinary/multiprofessional care based on standardized treatment concepts (guidelines, treatment pathways, etc.). It encompasses the integration of processes and organizations. (Source: ÖSG, https://goeg.at/OESG_2023)

Morbidity and mortality conferences

Morbidity and mortality conferences are a risk management and quality assurance tool used by healthcare facilities to systematically review specific courses of treatment, adverse events, deaths, etc. The goal is to jointly identify weaknesses – particularly in clinical processes – which then inform measures for improvement to be implemented. (Source: www.bundesaerztekammer.de)

Near miss

A near miss is an error that does not result in an adverse event. It is an error that does not cause harm but had the potential to cause harm. (Source: www.aps-ev.de)

Never events

Never events are clearly identifiable serious incidents related to clinical treatment that lead to patient harm or death and that can be preventable through system design and/or targeted preventive measures. (Source: "Never Events" – list for Austria, BMASGPK, www.sozialministerium.at)

Patient safety

According to § 2(4) of the Health Quality Act, patient safety encompasses "measures to prevent adverse events that could cause harm to the patient". (Source: GQG)

"A framework of organized 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." (WHO 2021) (Source: https://www.who.int/teams/integrated-health-services/patient-safety/policy/global-patient-safety-action-plan)

Patient safety officer

A patient safety officer is a member of staff in a healthcare facility who is assigned to promote and monitor patient safety in the facility. This role includes, in particular, responsibility for safety-related issues in the facility, including the identification of risks and the development and implementation of measures to prevent errors as well as the organization of training for healthcare professionals in safety-related processes. The role of a patient safety officer does not involve any liability claims, however; there is a clear demarcation of legal responsibility here. (Source: definition provided by GÖG)

Point of care

The term point of care refers to the place where diagnosis, treatment or care is provided directly to the patient. This includes, for example, a hospital bed, a general practitioner's practice or an ambulance. (Source: definition provided by GÖG)

Reporting and learning systems

Reporting and learning systems are tools that can be used to identify and analyse critical incidents to inform measures for improvement. A distinction can be made between in-house and cross-organizational reporting and learning systems. The goal of such systems is to promote an open error culture and the structured processing of adverse events without assigning blame. (Source: www.sozialministerium.at)

Risk

In the context of clinical risk management, risk is an uncertainty in healthcare that, with an estimated probability of occurrence and impact, harms patients, those involved in their care and/or the organization. (Source: APS, www.aps-ev.de)

Risk management

The sum total of strategies, structures, processes, instruments and activities in prevention, diagnostics, therapy and care that support employees at all levels, in all functions and in all areas of work in identifying, analysing, assessing and managing risks in patient care in order to increase the safety of patients, those involved in their care and the organization itself. (Source: APS, www.aps-ev.de)

Safety culture

The safety culture of an organization is the product of the values, attitudes, perceptions, competences and patterns of behaviour that determine the nature and effectiveness of the organization's safety measures. Organizations with a positive safety culture are characterized by communication based on mutual trust, shared perceptions of the importance of safety and confidence in the efficacy of preventive measures (Vincent 2006).

Second victim

The "second victim" phenomenon describes the stress and trauma experienced by medical professionals (e.g. doctors, nursing staff) after an error or an unexpected negative outcome in patient care. Along with the patients (first victims) and their relatives, doctors, nursing staff and other medical staff often suffer from feelings of guilt, stress and isolation, amongst other things. (Source: www.secondvictim.at)

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