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An Overview of the Patient Safety Programme at WHO

Albert Wu, MD, MPH
Cyrus Engineer, DrPH, MHA, MHS
Johns Hopkins University
Section A

WHO Patient Safety—Introduction and Global Patient Safety Challenges
An Introduction to the World Health Organization

- UN’s authority on international health
- Experts produce guidance and standards
- Helps countries address public health issues
- Supports and promotes health research
- Through WHO, governments can jointly tackle health problems
WHO Regions

- Six WHO regions with HQ in Geneva
Patient Safety

- Patient Safety is set up as a special programme following WHA Resolution 55.18 to coordinate, disseminate, and accelerate improvements in patient safety worldwide.
WHO Patient Safety Programme

- Launched in 2004 following the WHA resolution which called for member states to “pay the closest possible attention to the problem of patient safety”

- Promote awareness and political commitment

- Expert-led technical programmes to improve patient safety worldwide

- Previously referred to as the “World Alliance for Patient Safety”
Putting Safety on the World’s Agenda

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WHO Patient Safety Programme: Organisation

- Alliance chair: Sir Liam Donaldson
- Alliance secretariat: WHO HQ (Geneva) and London
- Expert leads
- WHO Collaborating Centres
- WHO Regional Patient Safety Focal Points
How We Do Our Work: Strategizing Patient Safety

Creating Safer Health Care

- Raise awareness & understand problem
- Develop solutions
- Strengthen capacity
- Build sustainable partnerships
- Scale up & evaluate impact
WHO Patient Safety: Our Areas of Work

- Global patient safety challenges
  - Clean care is safer care (GPSC 1)
  - Safe surgery saves lives (GPSC 2)
  - Antimicrobial resistance (GPSC 3)

- Reporting and learning

- Classification

- Research

- Patients for Patient Safety

- Safety solutions
Global Patient Safety Challenges (GPSC)

- First Global Patient Safety Challenge (GPSC1): Clean Care Is Safer Care

- WHO Guidelines for Hand Hygiene in Health Care
GPSC2: Safe Surgery Saves Lives

- WHO Guideline for Safe Surgery

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## WHO Surgical Safety Checklist

### Surgical Safety Checklist (First Edition)

<table>
<thead>
<tr>
<th>Sign In</th>
<th>Time Out</th>
<th>Sign Out</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Before induction of anaesthesia</strong></td>
<td><strong>Before skin incision</strong></td>
<td><strong>Before patient leaves operating room</strong></td>
</tr>
</tbody>
</table>

#### Sign In
- **Patient has confirmed:**
  - Identity
  - Site
  - Procedure
  - Consent
- **Site marked/not applicable**
- **Anaesthesia safety check completed**
- **Pulse oximeter on patient and functioning**
  - **Does patient have a:**
    - Known allergy?
      - No
      - Yes
    - Difficult airway/aspiration risk?
      - No
      - Yes, and equipment/assistance available
  - **Risk of >500ml blood loss (7ml/kg in children)?**
    - No
    - Yes, and adequate intravenous access and fluids planned

#### Time Out
- **Confirm all team members have introduced themselves by name and role**
- **Surgeon, anaesthesia professional and nurse verbally confirm:**
  - Patient
  - Site
  - Procedure
- **Anticipated critical events**
  - **Surgeon reviews:** What are the critical or unexpected steps, operative duration, anticipated blood loss?
  - **Anaesthesia team reviews:** Are there any patient-specific concerns?
  - **Nursing team review(s):** Has sterility (including indicator results) been confirmed? Are there equipment issues or any concerns?
  - **Has antibiotic prophylaxis been given within the last 60 minutes?**
    - Yes
    - Not applicable
  - **Is essential imaging displayed?**
    - Yes
    - Not applicable

#### Sign Out
- **Nurse verbally confirms with the team:**
  - The name of the procedure recorded
  - That instrument, sponge and needle counts are correct (or not applicable)
  - How the specimen is labelled (including patient name)
  - Whether there are any equipment problems to be addressed
  - **Surgeon, anaesthesia professional and nurse review the key concerns for recovery and management of this patient**
GPSC3: Tackling Antimicrobial Resistance

- Urgent public health issue
- A pandemic of resistance
- Building a coalition to address this
Section B

WHO Patient Safety—Work Streams
Reporting and Learning

WORLD ALLIANCE FOR PATIENT SAFETY

WHO DRAFT GUIDELINES FOR ADVERSE EVENT REPORTING AND LEARNING SYSTEMS

FROM INFORMATION TO ACTION

World Health Organization
Classification for Patient Safety: Conceptual Framework

International classification for patient safety

Conceptual framework

- System resilience (pro-active & reactive risk assessment)
- Clinically meaningful, recognizable categories for incident identification & retrieval
- Descriptive information

Diagram:
- Influences to Contributing factors/hazards
- Informs to Incident type
- Incident characteristics
- Patient characteristics
- Detection
- Influences to Mitigating factors
- Informs to Organizational outcomes
- Patient outcomes
- Ameliorating factors
Building Sustainable Partnerships

- Patients for Patient Safety
Patients for Patient Safety (PFPS)

- The “soul” of the WHO Patient Safety Programme

- PFPS champions
  - 2005 inaugural event in London
  - PFPS events in each WHO region
    - PAHO, EMRO, SEARO, and now EURO
  - Network of over 100 champions in different countries
Patient Safety Is Everybody’s Business

- Key partnerships
  - Health professionals
  - Trade unions
  - Religious organizations in health care
  - NGOs
  - Student bodies
  - Patient organizations, CAPS, IAPO, etc.
  - WHO HQ programmes
  - Patients for Patient Safety champions
Research for Safer Care

- **Aim:** To devise solutions to make care safer and reduce harm to patients
  - Measure magnitude and type of adverse events leading up to harm
  - Understand the underlying causes of patient harm
  - Identify solutions to make health care safer
  - Evaluate the impact of solutions in real-life settings
Global Agenda for Research

- Developing country priorities
  1. Development and testing of locally effective and affordable solutions
  2. Cost-effectiveness of risk-reducing strategies
  3. Counterfeit and substandard drugs (including traditional medicines)
  4. Inadequate competences, training, and skills
  5. Maternal and newborn care
  6. Health care–associated infections
  7. Study of the extent and nature of the problem of patient safety
  8. Lack of appropriate knowledge and transfer of knowledge
  9. Unsafe injection practices
  10. Unsafe blood practices

- Developed country priorities
  1. Lack of communication and coordination (including hand-offs)
  2. Latent organizational failures
  3. Poor safety culture and blame-oriented processes
  5. Developing better safety indicators (including a global safety indicator)
  6. Procedures that lack human-factors consideration built into design
  7. Health information technology/information systems
  8. Patients’ role in shaping the research agenda
  9. Devices that lack human-factors consideration built into design
  10. Adverse drug events/medication errors
Small Research Grants

- 500,000 USD per year to support 20 to 30 small studies worldwide
- Targeting applied research to identify locally effective solutions
- Twenty-one grants allocated in 2009
  - Tunisia, Iran, Pakistan, China, The Philippines, Vietnam, Myanmar, New Zealand, Thailand, Chile, Peru, Venezuela, Brazil, Mexico
Safety Solutions

- Premise: “No adverse event should ever occur anywhere in the world if the knowledge exists to prevent it from happening”

- Solution: Present the problem, strength of evidence supporting the solution, potential barriers to adoption, risks of unintended consequences created by the solution, patient and family roles in the solution, and references and other resources
Safety Solutions Issued

- Look-alike, sound-alike medication names
- Patient identification
- Communication during patient handovers
- Performance of correct procedure at correct body site
- Control of concentrated electrolyte solutions
- Assuring medication accuracy at transitions of care
- Avoiding catheter and tubing misconnections
- Single use of injection devices
- Improved hand hygiene to prevent health care–associated infection
Other PSP Work Streams

- Technology for patient safety

- Capacity building for patient safety
  - Safety scholars
  - African partnerships for patient safety

- Building on the success of the Safe Surgery Checklist
Where Will We Be in Five Years?

- **Patients can expect cleaner care** through improved hand hygiene

- **Surgery is safer** with the use of the surgery checklist

- **Resistance to frontline antimicrobials is falling** through national and local campaigns

- **Learning is broader** with improved global knowledge management and partnership

- **Appreciation for safety research** and building capacity

- **Patients are partners** in preventing avoidable harm in the health care setting
The Patient Safety Programme

- The Patient Safety Programme aims to coordinate, disseminate, and accelerate improvements in patient safety worldwide

- Web site
  - www.who.int/patientsafety