

WHO Patient Safety Newsletter

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News in brief

An information booklet about **African Partnerships for Patient Safety** will be launched at a workshop in Uganda next month. Copies will be available in English and French on the WHO Patient Safety website from late October.

Promotion of the importance of **pulse oximeters**, one of the outcomes of the WHO Surgical Safety Checklist launched last year, will be given a boost at a WFSA conference in Nairobi this October.

The **influenza A (H1N1) pandemic** continues to be a priority for WHO. WHO Patient Safety made a major contribution to the Patient Care Checklist launched earlier this year and is currently engaged in a global evaluation exercise of this.

WHO Patient Safety will have a stand at this year's **ISQua conference** to be held in Dublin next month. Emphasis will be on patient safety research and knowledge sharing to increase and heighten global awareness.

Applications for the **WHO Patient Safety Research Small Grants** close on 30 September. All information about the grant programme is available on the website: www.who.int/patientsafety/research/grants.

A new **Safe Childbirth Checklist** outlining a core set of practical standards to improve the safety and quality of health care at the time of a baby's birth is being developed by WHO Patient Safety, working with colleagues across WHO. More information at:

www.who.int/patientsafety/implementation/checklists/childbirth

Editorial

Sir Liam Donaldson - Chair, WHO Patient Safety



Safe health-care delivery can only take place in the context of robust and reliable organizations. To achieve this, emphasis has been placed on re-engineering health-care systems to create high reliability organizations. Work like this has contributed significantly to the safety of the airline, nuclear and oil-rig industries, where risk is carefully managed to prevent harm.

The transformation of health-care systems must be accompanied by the training of safe health-care professionals. To deliver safe health care, clinicians require training in the discipline of patient safety. This includes an understanding of the nature of medical error, how clinicians themselves can work in ways that reduce the risk of harm to patients, techniques for learning from error, and how clinicians can harness

quality improvement methods to improve patient safety in their own organizations.

Earlier this year, WHO Patient Safety launched the Patient Safety Curriculum Guide for Medical Schools. This has been downloaded over a thousand times in the last six months. Over the next year the guide will be piloted and evaluated in medical schools across nine countries worldwide.

Patient safety education and training is vital for everyone involved in the delivery of health care. Consultation has begun with international groups representing midwifery, nursing, pharmacy and others to review how the Patient Safety Curriculum Guide can be adapted for use by all health-care professionals.

The weaving together of both these strands – safer systems and safer clinicians – has the potential to achieve the goal of all this work: to make health care safe for patients.

Hand hygiene technical meeting - a great success

At the end of August, WHO Patient Safety hosted a two day technical meeting for campaigning countries to highlight work achieved to date, share data and discuss the way forward. The basis of the meeting was the initiative **SAVE LIVES: Clean Your Hands** which was launched on 5 May this year. To date, over 5700 hospitals worldwide have registered their commitment to this initiative and to using the WHO tools to improve hand hygiene at the bedside. This represents over four million staff and over 1.7 million hospital beds globally. The aim is to have 10,000 hospitals signed up by May 2010. All the tools and resources developed to help improve infection control are available on the website at: <http://www.who.int/gpsc/5may/tools/en/index.html>.

Guest Editorial

Professor Peter Pronovost, Johns Hopkins University



Over the last decade, the health-care industry has realized that medical errors are a global problem that affect developed and developing countries. To date, the struggle to make health care safer has been plagued by independent rather than interdependent efforts, resulting in competition rather than

cooperation, and focusing too much on policies and efforts rather than actual results.

The environment is changing. The field of patient safety and quality control has evolved into a scholarly discipline rooted in science and coupled with robust measurement. Thanks to this new approach and WHO's leadership and support, the world community is collaborating to put an end to preventable harm. A major lesson we have learned is that one approach will not fit all safety issues. Instead, our efforts should address seven distinct areas: developing tools to improve safety and measures to gauge results, making sure the latest treatments are available to all patients, identifying and mitigating safety issues, assessing and improving culture and communication, organizing resources needed to implement programmes, and reducing diagnostic errors.

So far the global community has moved forward in addressing both culture and evidence-based practice. Our Comprehensive Unit-Based Safety Program (CUSP), which addresses culture and communication among clinicians, was combined with our model to Translate Evidence into Practice (TRIP), which ensures that the latest research to prevent central line-associated bloodstream infections is reaching patients. This hybrid program nearly eliminated bloodstream infections across the state of Michigan. We have applied this same model called On the CUSP; STOP BSI (bloodstream infections) state-by-state in the United States and in England, Spain, and Peru. These programmes include a robust system to measure results to ensure that infection rates are actually dropping.

Moreover, we are working with WHO Patient Safety to help countries learn better ways to track and report medical incidents. The Canadian Patient Safety Agency recently hosted the second international meeting of all countries that have or plan to have incident reporting systems. England (one country at that meeting)

is a leader in this field. Their main safety research body, the National Patient Safety Agency (NPSA), developed the National Reporting and Learning System (NRLS) to collect and analyse errors across England and Wales. The NPSA is investigating novel models to analyse and reduce adverse events and countries are sharing what they learn.

What's truly exciting about this new age of patient safety research is the formation of a global community of researchers, regulators, health ministers, professional societies, patients, and providers partnering to help reduce preventable harm. Global efforts such as the WHO hand hygiene campaign and the Safe Surgery Checklist are strong examples of these joint efforts.

However, much work stands before us. We are at the forefront of shaping this new discipline in health care and we all have an important role to play in this global effort. It must be driven by science and results. Sorrel King, the mother of an adorable 18-month old girl named Josie who died from preventable mistakes, once asked me if health care was any safer than ten years ago. She and all patients deserve an answer. Before we can clearly say yes, we need to build the capacity of researchers and clinicians to do safety work, and invest sufficient resources in research that reflects the magnitude of the problem. Most importantly, we must have the courage to believe that we can achieve this goal. Deaths from medical errors are not inevitable but preventable. We must have this clarity of the task before us and commit to rolling up our sleeves and making it a reality.

Patient safety research

Research into patient safety issues is stepping up with initiatives in development and current work due for publication. A list of global priorities indicating areas where there are substantial knowledge gaps and where it is expected that further knowledge will contribute to reducing harm was published earlier this year and is available for download at:

http://www.who.int/patientsafety/research/priorities/global_priorities_patient_safety_research.pdf.

A profile of the results is currently being published for advocacy purposes, to encourage international interest in patient safety research at country level. Further research has been completed into patient safety in hospitals in the African and South East Asian regions of WHO and is due for publication later this year.

The next edition of this newsletter will be published in December 2009. To subscribe email patientsafety@who.int.



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A World Alliance for Safer Health Care

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