

WHO Collaborating Centre Accomplishments
WHO Collaborating Centre for Patient Safety (Solutions)
January 2007

Review of the accomplishments of the World Health Organization (WHO) Collaborating Centre for Patient Safety (Solutions).

Key Points

1. The WHO formally designated The Joint Commission and Joint Commission International (JCI) as the Collaborating Centre for Patient Safety Solutions in July 2005.
2. The 2006 deliverables for the Collaborating Centre were as follows:
 - Finalize drafts for 10-12 solutions
 - Convene International Steering Committee
 - Convene Regional Advisory Committees
 - Initiate the Field Review process for the designated solutions
3. The foregoing deliverables have been accomplished, as described below, along with additional information about other activities underway.

Accomplishments

The following are the major accomplishments of the Collaborating Centre in 2006.

Patient Safety Solutions

1. A definition was developed for a Patient Safety Solution. A Patient Safety Solution is defined as any system design or intervention that has demonstrated the ability to prevent or mitigate patient harm stemming from the processes of health care.
2. The Centre developed timelines for solutions development, a template for the solutions, and a structured process for obtaining input to develop and refine candidate solutions.
3. The Solutions are evidence-based, presented in a standard format, and describe in simple terms what to do to address the risks associated with a particular safety problem. Each individual solution presents the problem, provides a series of recommendations, describes the strength of the evidence in support of the solution recommendations, presents potentially necessary adaptations for specific countries or world regions, discusses potential barriers to adoption, identifies risks of unintended consequences created by the solution, describes potential patient and family roles in the solution, and lists references and other resources.
4. Criteria for the evaluation of solutions were created. Scoring guidelines and a process for evaluation of the proposed solutions were adopted. An approach to grading the strength of the evidence in support of the solution has been adopted.

5. An initial selection of 12 potential Solutions was developed for consideration by the Centre's International Steering Committee which was subsequently narrowed to nine. The proposed Solutions are:
 - Look-Alike, Sound-Alike Medications
 - Patient Identification
 - Hand-Off Communications
 - Wrong Site / Wrong Procedure / Wrong Person Surgical
 - High-Concentration Drug Errors
 - Medication Reconciliation
 - Catheter and Tubing Misconnections
 - Needle Reuse and Injection Safety
 - Hand Hygiene
6. Further revision of the selected Solutions was undertaken with the active involvement of Steering Committee members. The draft solutions were then vetted with various expert panels and advisory groups (described below). Based upon input from these groups, the Kernicterus Solution was considered for further development.
7. The nine Solutions listed above are now undergoing a major international field review that is being conducted in a fashion similar to that for Joint Commission standards, using an electronic survey that can be accessed online. The field review audience includes leading patient safety entities, accrediting bodies, Ministries of Health, international health professional associations, and WHO and Joint Commission International network of contacts. The field review is available on both the Centre and WHO websites.
8. The field review was initiated on November 28, 2006 and extends through February 16, 2007. The final versions of the Solutions will be returned to the Steering Committee for final review and approval at its meeting on April 4-5, 2007. The final Solutions will be published in a format similar to the WHO '*Aide Memoire*'. The target date for dissemination of the initial set of Solutions is May 2007.
9. A Solution regarding the use of Vincristine was drafted and will be used as a prototype for '*Aide Memoire*' development.

Collaborative Network

1. Another priority has been the development of a collaborative network to facilitate the identification of high priority patient safety problems and potential solutions around the world. The previously-referenced International Steering Committee, whose membership is drawn from every continent (except Antarctica) is the cornerstone of the network. The Steering Committee includes experts from leading patient safety organizations around the world. The first meeting of the International Steering Committee was convened by the Collaborating Centre in June 2006.
2. Regional Advisory Groups have already been established in the Far East, Middle East, and Europe and have each met twice. Efforts are now focused on establishing similar Regional Advisory Groups in South America and Africa.

3. Collaborative work with nine other established patient safety leadership organizations in the U.S. continues. These organizations are referred to as Champions for Patient Safety (a group which includes the Joint Commission International Centre for Patient Safety).
4. Three Expert Panels have been established to advise the Joint Commission International Centre for Patient Safety on key topical areas, many of which cross-reference the Solutions development initiative. These include the Patient and Family Advisory Group, Communications Expert Panel, and Medication Safety Expert Panel. These groups have also already met.
 - Patient and Family Advisory Group – This Group is composed of leading U.S. patient safety advocates, and has a formal link with the Patients for Patient Safety programme of WHO's World Alliance for Patient Safety.
 - Communications Expert Panel – This panel is composed of experts from the health care field and other relevant industries such as aviation. This group has identified a comprehensive list of communications issues that involve team building, culture, and human factors, among others. Consideration is being given to developing generic templates, or protocols, for communication practices in selected clinical situations.
 - Medication Safety Expert Panel – This panel is composed of experts on the topics relating to medication management and safety. This group is to be augmented with international medication safety experts in the future.
5. Additional network building at the international level continues. This effort encompasses WHO, the International Hospital Federation, the International Council of Nurses, the World Medical Association, the Organization for Economic Cooperation and Development, national patient safety agencies, ministries of health, and others.
 - A meeting with the international accrediting bodies took place in London in October at the annual meeting of the International Society for Quality in Health Care (ISQua), and it was agreed that the Centre would meet with this group on an annual basis at ISQua meetings.
 - A letter introducing the Collaborating Centre was sent to many Ministries of Health worldwide, inviting their strategic partnership and collaboration. The letter included an online survey that requested information regarding the patient safety problems in their country, and effective patient safety solutions already in use.

High 5s Initiative

1. The “Patient Safety in Action” (High 5s) initiative was announced in December 2006. This initiative is co-sponsored by the Commonwealth Fund and the WHO World Alliance for Patient Safety. The Collaborating Centre is the Principal Investigator for the project.
2. The High 5s initiative will build on the established partnership and collaboration by the Commonwealth Fund with Australia, Canada, Germany, the Netherlands, New Zealand, the

United Kingdom, and the United States. Selected hospitals in these countries will be the actual participants in the project.

3. The objective of the project is to achieve significant, sustained, and measurable reduction in the occurrence of five patient safety problems over five years in seven countries within a collaborative, learning network that fosters the sharing of knowledge and experience in implementing innovative standardized implementation protocols that are based on the Patient Safety Solutions.
4. The following five solution areas have been selected as the focus for this initiative:
 - Patient Care Hand-Overs
 - Wrong Site/Wrong Procedure/Wrong Person Surgery
 - Medication Reconciliation
 - High-Concentration Drug Errors
 - Hand Hygiene
5. Each of the seven countries participating in this project will designate a technical agency to lead country-level actions. Approximately ten hospitals in each country will be expected to voluntarily enroll in the initiative and commit to implement one or more Solutions.

Website Activities

1. The Centre's website — www.jcpatientsafety.org — was launched in March 2005 and its infrastructure has continually evolved with major improvements being put in place in January 8, 2007.
2. An online compendium of Patient Safety Practices now resides on the Centre's website and provides links to safe practices, forms, tools, and other valuable information on other international patient safety websites. The compendium was launched in April 2006 and now includes over 800 links. This site is organized based on the experience gleaned from the Sentinel Event database, with topics listed under the headings "Types of Adverse Events" and "Causes of Adverse Events". The site can be accessed from the Centre home page, from the Joint Commission website home page, and at www.jcpatientsafety.org/psp. As the International Patient Safety Events Taxonomy is finalized, the compendium will be re-organized to fit this classification scheme.
3. The complimentary electronic newsletter, or "e-zine," called Patient Safety Link continues to be distributed monthly. The newsletter features updates on Centre activities. All issues of the Patient Safety Link are archived on the Centre website so that the content can continue to be accessed as new issues are produced.
4. The High 5s initiative contemplates the development of comprehensive web site support to promote the implementation of the five selected solutions. This site will provide resources to participants in the High 5s project, as well as to others who are implementing the solutions as part of the WHO Alliance for Patient Safety initiative. The Centre will be the host for this resource.