



WORLD ALLIANCE FOR PATIENT SAFETY

# FORWARD PROGRAMME

2006-2007



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World Alliance for Patient Safety

**Forward Programme**  
**2006–2007**

# WORLD ALLIANCE *for* PATIENT SAFETY



World Health  
Organization



ORGANISATION  
MUNDIALE DE LA SANTÉ  
WORLD HEALTH ORGANIZATION  
ORGANIZACION MUNDIAL  
DE LA SALUD

## **ABOUT THE WORLD ALLIANCE FOR PATIENT SAFETY**

In May 2002, the Fifty-fifth World Health Assembly adopted WHA Resolution 55.18, which urged Member States to pay the closest possible attention to the problem of patient safety and to establish and strengthen science-based systems necessary for improving patient safety and the quality of health care.

In May 2004, the Fifty-seventh World Health Assembly supported the creation of an international alliance to facilitate the development of patient safety policy and practice in all Member States and act as a major force for improvement internationally.

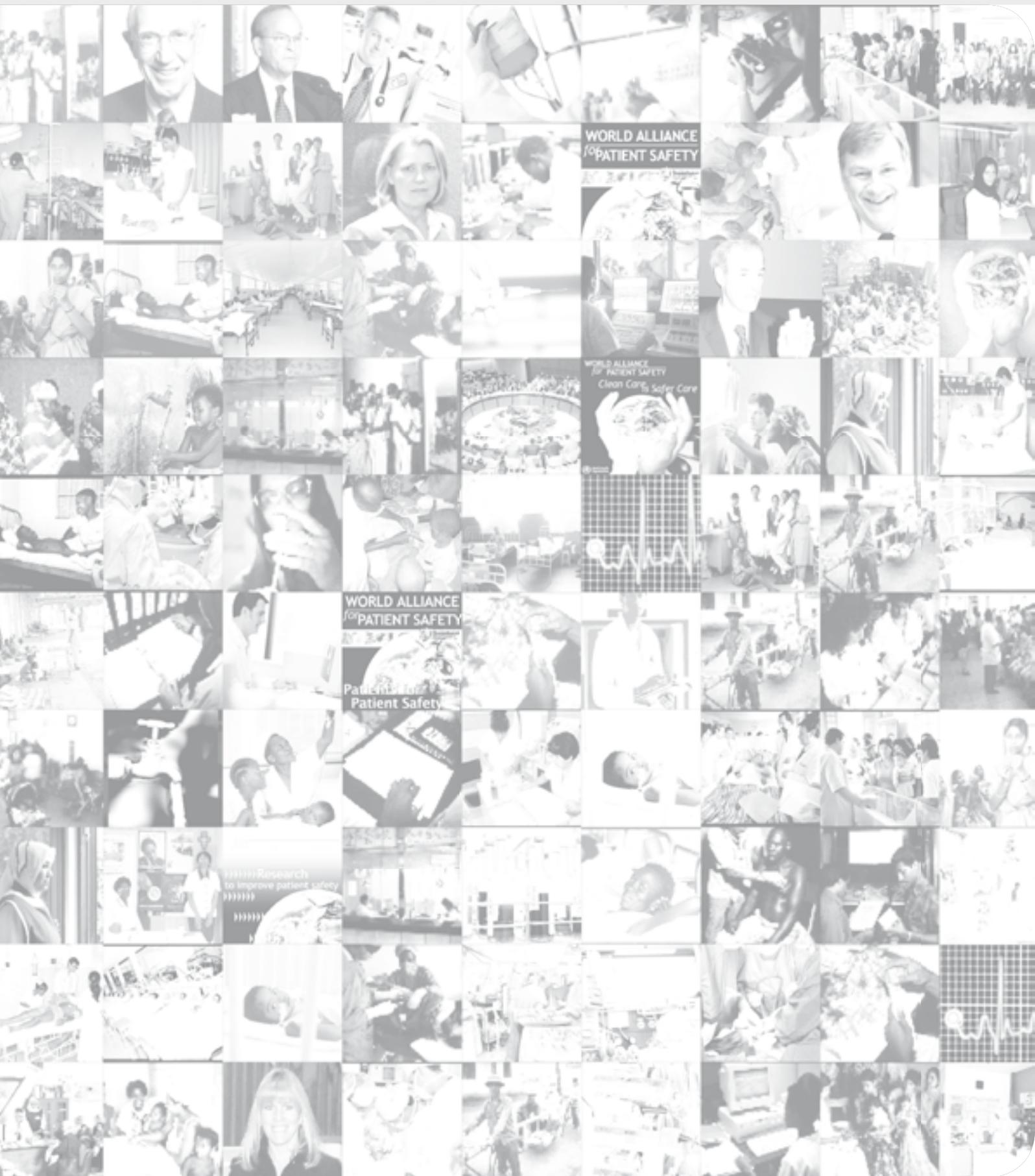
The World Alliance for Patient Safety was launched in October 2004. The Alliance is chaired by Sir Liam Donaldson.

The World Alliance aims to fulfill the requirements of WHA Resolution 55.18 through international leadership and by creating an over-arching strategy, action programmes and a coalition of nations, stakeholders and individuals to transform the safety of health care worldwide.

### **THE BOTTOM LINE**

“Real leadership and commitment are required if we are to fight a problem that can affect every patient in the world and to reduce the appalling costs of unsafe care. It is needed to draw on the strengths and contributions of all parts of society through broad-based partnerships. And it is instrumental to mobilizing national and international knowledge and resources on a scale far greater than we have so far.”

**Dr LEE Jong-wook** , Director-General, World Health Organization 2003-2006



WORLD ALLIANCE  
for  
PATIENT SAFETY

WORLD ALLIANCE  
for PATIENT SAFETY  
Clean Care, Safer Care

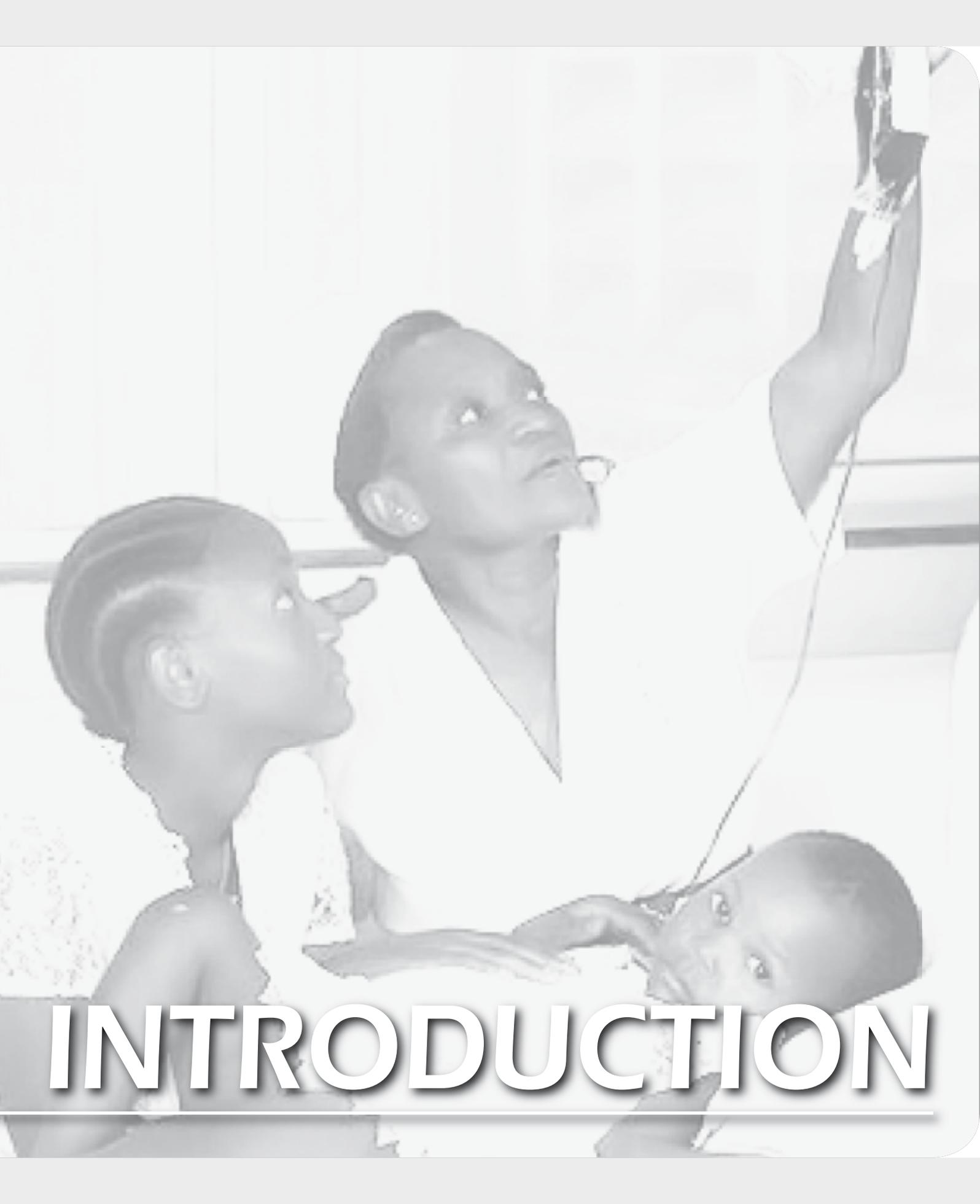
WORLD ALLIANCE  
for PATIENT SAFETY

Patients for  
Patient Safety

Research  
to improve patient safety

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# INTRODUCTION



Health care which is as safe as possible, as soon as possible — this is the simple, yet powerful mandate given to the World Alliance for Patient Safety by patients around the world.

In its simplicity lies a significant challenge for all health-care systems.

Globally, action on patient safety is gaining momentum. Health-care policy-makers around the world are making patient safety a priority. Work on the Alliance's international action areas is gaining pace.

However, the case for even greater action is compelling and urgent. Errors in health care know no geographical boundaries. No country — rich or poor — can claim to have fully come to grips with the problem of patient safety.

Improving patient safety requires carefully designed systems of care which reduce risks to patients. Complementary actions are needed to prevent adverse events, make them quickly visible when they do occur, mitigate their effects on patients and health-care workers and reduce risks to future patients. Change is needed at the level of individual health-care workers, teams, organizations and whole health-care systems. Competent, conscientious and safety-conscious health workers in frontline services are vital.

As the Alliance has undertaken work throughout the world, a series of common challenges have emerged.

First: the need to raise awareness of the size of the patient safety problem and build political commitment to action. Patient safety is a big and serious problem and risk is an inherent feature of many aspects of health care. Without strong and committed leadership the patient safety movement cannot succeed.

Second: solving safety problems for which we already have ample information about causes and solutions. It is striking that the same errors and system failures are repeated not only across but also within countries. Action to address known risks is often too slow and poorly implemented.

Third: the problem of timely identification of new issues and their solutions. Despite increased effort, our systems to detect risk and patient safety problems are still primitive. Even when adverse events do occur, many of them are not reported by health-care workers. A culture of blame — rather than a culture of learning — is alive and well. Blame and retribution cause harm and prevent safety flourishing.

Inadequate systems for detecting problems mean that our understanding of the causes of patient safety problems is incomplete. This is the knowledge we must have if we are to design effective solutions. Knowledge is the enemy of unsafe care.

Fourth: developing open partnerships with patients. Health-care organizations are typically defensive in dealing with patients and their carers in the aftermath of a serious event. Patients and their carers are rarely asked for feedback on risks and problems. The wisdom of patients is not effectively harnessed.



This Forward Programme 2006-2007 sets out an ambitious and comprehensive agenda for action on patient safety. Everyone working in health care needs to play their part. The stakes could not be higher. Safe care is not an option. It is the right of every patient who entrusts their care to our health-care systems.

**Sir Liam Donaldson, Chair, World Alliance for Patient Safety**

## **FORWARD PROGRAMME 2006–2007**

Through concerted effort in key priority areas, the World Alliance for Patient Safety aims to:

- Support the efforts of Member States to promote a culture of safety within their health-care systems and develop mechanisms to enhance patient safety;
- Put patients at the heart of the international patient safety movement;
- Catalyse political commitment and global action on areas of greatest risk to patient safety through the Global Patient Safety Challenge;
- Develop global norms, standards and guidelines for ways of detecting and learning from patient safety problems to reduce risks for future patients;
- Make safety solutions widely available to all Member States in ways which are as easy as possible to implement and relevant to their needs;
- Develop and spread knowledge about evidence-based policies and best practices in patient safety;
- Build consensus on common concepts and definitions of patient safety and adverse events;
- Initiate and foster research in areas which will have most impact on safety problems;
- Explore ways in which new technologies such as simulation methods can be harnessed in the interest of safer care;
- Bring together partners to contribute towards knowledge development and social mobilization;
- Target technical work to reflect the patient safety priorities both of developed and developing countries.





## ACTION AREAS 2006–2007

Action area 1	<p>The <b>Global Patient Safety Challenge</b> will galvanize global commitment and action on a patient safety topic which addresses a significant area of risk for all Member States.</p> <p>In 2005–2006, the Global Patient Safety Challenge is focussing on health care-associated infection with the theme <i>Clean Care is Safer Care</i>.</p> <p>For 2007–2008, the Global Patient Safety Challenge will focus on the topic of safer surgery with the theme <i>Safe Surgery Saves Lives</i>.</p>
Action area 2	<b>Patients for Patient Safety</b> will ensure that the voice of patients is at the core of the patient safety movement worldwide.
Action area 3	<b>Reporting and Learning</b> will promote valid reporting, analytical and investigative tools and approaches that identify sources and causes of risks in a way that promotes learning and preventative action.
Action area 4	<b>Taxonomy for Patient Safety</b> will develop an internationally acceptable system for classifying patient safety information to promote more effective international learning.
Action area 5	<b>Research for Patient Safety</b> will facilitate an international research agenda which supports safer health care in all WHO Member States.
Action area 6	<b>Safety Solutions</b> will translate knowledge into practical solutions and disseminate these solutions internationally.
Action area 7	<b>Safety in Action</b> will spread best practices for implementation of changes in organizational, team and clinical practices to improve patient safety
Action area 8	<b>Technology for Patient Safety</b> will focus on the opportunities to harness new technologies to improve patient safety
Action area 9	<b>Care of acutely ill patients</b> will identify key patient safety priorities for action in the care of seriously ill patients.
Action area 10	<b>Patient safety knowledge at your fingertips</b> will work with Member States and partners to gather and share knowledge on patient safety developments globally in the form of a global report.

## AT A GLANCE: KEY DELIVERABLES FOR 2006–2007

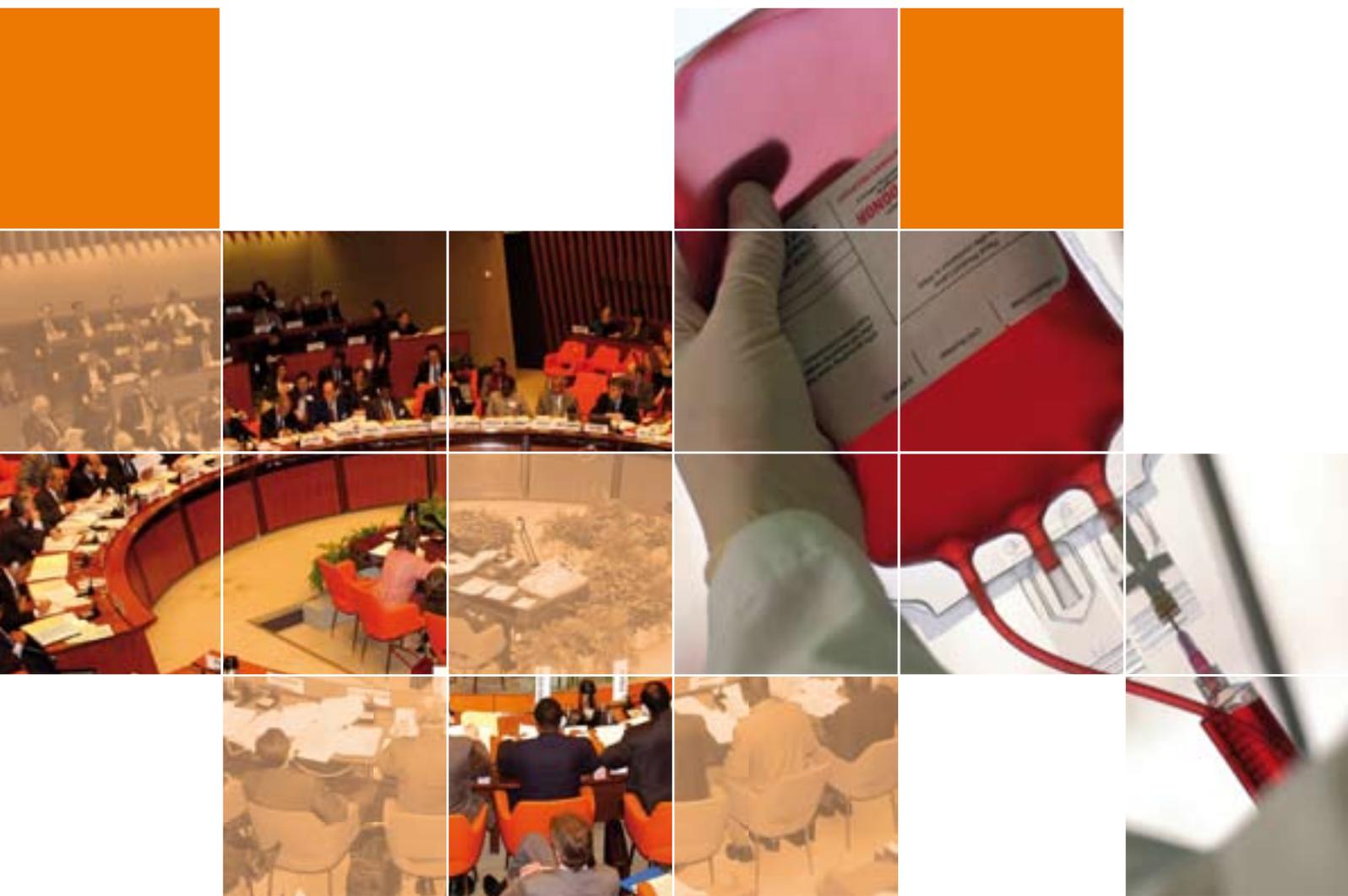
1. All WHO Member States have been invited to pledge to take action on health care-associated infection and improvements for cleaner and safer care have been initiated for over half the world's population during the life of the Global Patient Safety Challenge.
2. Finalized WHO Guidelines on Hand Hygiene in Health Care, as a result of consultation and pilot testing in all regions of WHO.
3. An international network of 100 patient champions for patient safety, drawn from all WHO regions, working in partnership with policy-makers and other key players to improve patient safety.
4. WHO Guidelines for Adverse Event Reporting and Learning Systems finalized on the basis of feedback through consultation and field experience.
5. Development of internationally acceptable patient safety research priorities.
6. Actionable data on the size and nature of patient safety problems in up to eight developing and transitional countries.
7. Six field-tested safety solutions disseminated to all Member States using a standardized template.
8. Development of an International Patient Safety Classification which has been the subject of wide consultation and field testing.
9. Production of the first Global Report on Patient Safety to share knowledge on patient safety developments internationally.
10. Five best practices on patient safety from the experience of leading-edge health facilities have been widely disseminated.
11. Development of an international agenda for technology for patient safety.
12. Development of an international agenda on patient safety and the care of acutely ill patients, in partnership with the International Partnership for Acutely Care Safety (IPACS).



**1**

**GLOBAL  
PATIENT  
SAFETY  
CHALLENGE**

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## INTRODUCTION

Every two years, the World Alliance formulates a Global Patient Safety Challenge to galvanize global commitment and action on a patient safety topic which addresses a significant area of risk for all WHO Member States.

In the period 2005–2006, the Global Patient Safety Challenge is focussing on health care-associated infection with the theme *Clean Care is Safer Care*.



For the period 2007–2008, the Global Patient Safety Challenge will focus on the topic of safer surgery with the theme *Safe Surgery Saves Lives*.

## CLEAN CARE IS SAFER CARE

The vision of the first Global Patient Safety Challenge was to catalyse worldwide commitment to make *Clean Care is Safer Care* an everyday reality everywhere health care is provided.

At any given time, 1.4 million people worldwide are estimated to be suffering from an infection acquired in a health facility. The risk of acquiring health care-associated infections in developing countries is 2–20 times higher than in developed countries<sup>1</sup>.

Launched in October 2005, the first Global Challenge comprises three major elements. First, the development and testing of the new WHO Guidelines on Hand Hygiene in Health Care. Second, global and national Clean Care is Safer Care campaigns. Third, an invitation to all Member States to pledge to take action on health care-associated infection.

A number of WHO collaborating departments, with established programmes relating to clean and safe care are working closely with the Global Challenge. These include injection safety, blood safety, immunization safety, clinical procedures, as well as water and sanitation.

### WHO TOOLS AND RESOURCES TO AID COUNTRY IMPLEMENTATION

#### Pilot test sites



- Regional workshops
- Technical assistance by WHO
- Implementation pack including:
  - Guide to implementation and sustainability
  - Suite of tools (evaluation, educational, promotional and technical)
  - On-site visits (as necessary)

#### Countries committed to address health care-associated infection



- Access to all tools and resources (website and hard copies)
- Targeted technical assistance by WHO

#### Complementary test sites



- Access to all tools and resources (website and hard copies)
- Targeted technical assistance by WHO

#### All countries



- Access to all tools and resources electronically via the Global Patient Safety Challenge website



## DURING 2006 AND 2007 THE GLOBAL PATIENT SAFETY CHALLENGE WILL:

1. Test the recommendations of the new WHO Guidelines on Hand Hygiene in Health Care (Advanced Draft) in six pilot sites worldwide;
2. Identify, develop, test and evaluate strategies for the implementation of the WHO Guidelines designed to assist countries in improving patient safety and saving lives by reducing the burden of health care-associated infections;
3. Undertake a major programme of global and national Clean Care is Safer Care awareness-raising campaigns;
4. Invite all Member States to demonstrate commitment to take action on health care-associated infection by signing a statement. The aim is to initiate improvements for cleaner and safer care for over half the world's population during the life of the Challenge.



**Professor Didier Pittet, Leader, Global Patient Safety Challenge 2005–2006: “Clean Care is Safer Care”**

“Clean Care is Safer Care”: Five words that can make a difference to you and your family. These five words correspond to each finger of your hand; one finger cannot do much alone but together they form a powerful group. The time for action and not just words has come. I invite you all to share our vision to make a major improvement in patient safety worldwide.

## SAFE SURGERY SAVES LIVES

The vision of the second Global Patient Safety Challenge, 2007-2008 is to catalyse worldwide commitment to make *Safe Surgery Saves Lives* an everyday reality wherever health care is provided.

For a century now, surgical care has been an essential component of public health systems—whether for patients with life-threatening traumatic injuries, cancers, and obstetric complications or for patients with disabling conditions such as hernias, cataracts or congenital anomalies. With a corresponding increase in the incidence of non-communicable diseases, the worldwide burden from these conditions has also grown.



An estimated sixty-three million people a year now require surgical treatment for traumatic injuries, thirty-one million for malignancies, ten million for obstetric complications<sup>2</sup>. Surgery, however, is among the most complex health service for systems to deliver and can be among the costliest. Problems associated with surgical safety are well recognized in many developed countries, accounting for at least half of the avoidable adverse events that result in death or disability. There are, however, few internationally agreed standards for the provision of these services.

In the developing world, the poor state of infrastructure and equipment, unreliable supply and quality of drugs, shortcomings in waste management and infection control, poor performance of personnel because of low motivation or insufficient technical skills and severe under-financing of essential operating costs of health services make the probability of adverse events even higher.

The second Global Patient Safety Challenge 2007-2008 *Safe Surgery Saves Lives*, comprises three major elements. First, the wide dissemination of a bundle of standards and tools which are required for safe surgery. These address matters such as the physical environment, supplies and equipment, surgical hygiene and infection prevention, team work and training of health-care workers. Second, global and national *Safe Surgery Saves Lives* campaigns. Third, an invitation to all Member States to pledge to take action to achieve safer surgery worldwide.

Close links will be developed with WHO collaborating departments with established programmes relating to safer surgery, including clinical procedures and blood safety within the Department of Essential Health Technologies.

During 2007, the second Global Patient Safety Challenge will:

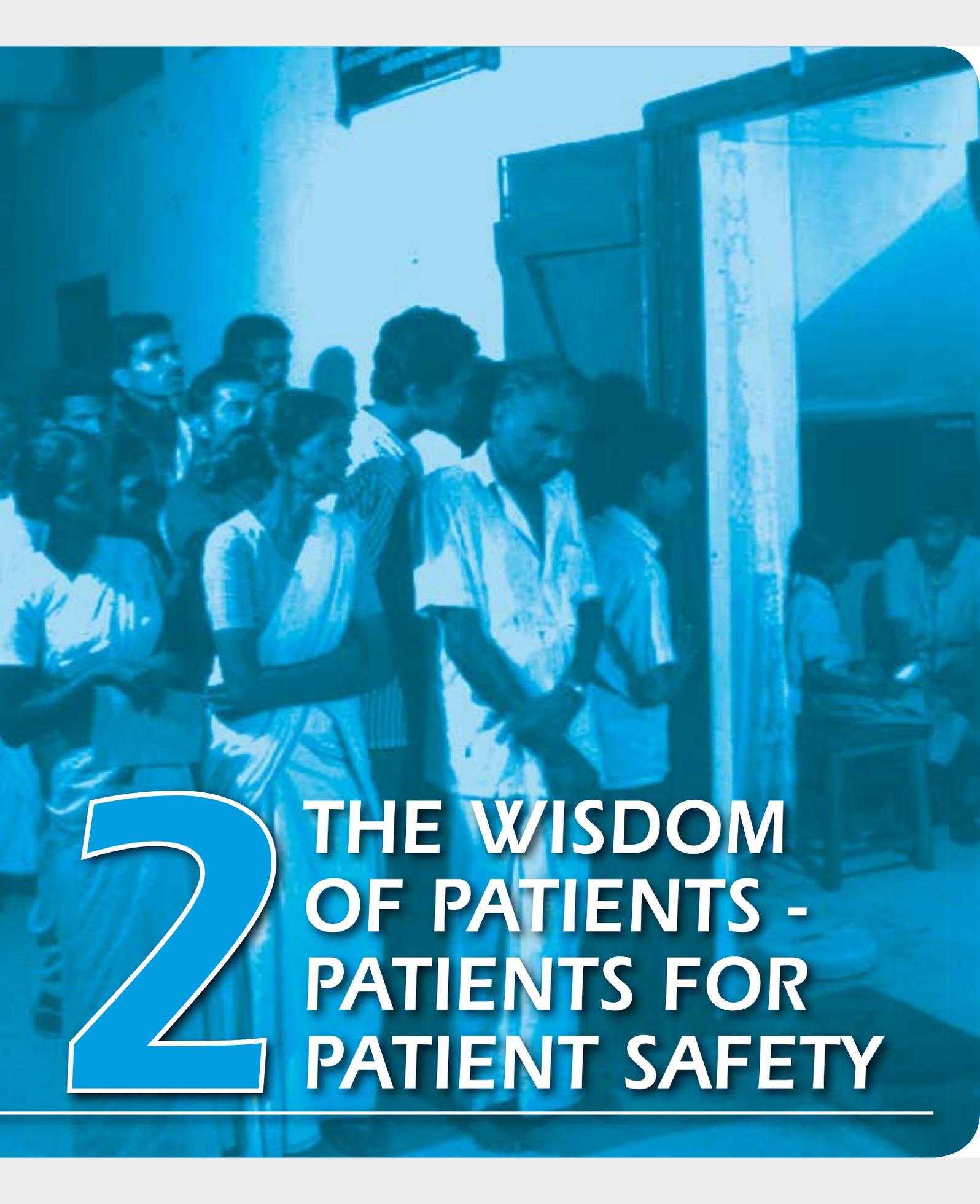
- Test and disseminate a bundle of standards and tools required for safe surgery;
- Initiate a major programme of global and national *Safe Surgery Saves Lives* awareness-raising work;
- Invite all Member States to demonstrate commitment to take action on safer surgery. The aim is to initiate improvements for over half the world's population during the life of the Challenge.



**Dr Atul Gawande, leading the second Global Patient Safety Challenge 2007-2008 “Safe Surgery Saves Lives”**

Surgical care has been an essential component of public health systems worldwide for a century. The quality and safety of that care has been dismayingly variable in every part of the world. The *Safe Surgery Saves Lives* campaign aims to change that by raising the standards that people everywhere can expect.





2

**THE WISDOM  
OF PATIENTS -  
PATIENTS FOR  
PATIENT SAFETY**

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Patient safety is not only about statistics, but damages the lives of real people - patients and families - who are harmed and sometimes die as a result of unsafe care.

Through the action area Patients for Patient Safety, the World Alliance aims to ensure that the voice of patients and consumers is at the core of the patient safety movement worldwide. Led by patients, Patients for Patient Safety, is building an international network of patients and consumers to promote patient leadership and involvement in patient safety initiatives at all levels, through advocacy and open dialogue.

Around the world, health-care organizations which are most successful in improving patient safety are those that encourage close cooperation with patients and their families.

Partnership is a key theme: patients, health professionals, policy-makers and health-care leaders working together to prevent avoidable harm in health care. A particular focus is to contribute an active patient perspective in all action areas of the Alliance's Forward Programme and to contribute to developing WHO regional patient safety strategies.

### **Patients for Patient Safety Workshop London, England, November 2005**

The world's first Patients for Patient Safety workshop was held in London in November 2005. The workshop brought together a group of 24 patients and patient safety advocates whose experience established them as committed patient safety champions. Workshop participants were drawn from 20 different countries and were selected following a worldwide call, reaching over 2000 organizations. The workshop endorsed a declaration calling for a greater role for patients to improve patient safety internationally. Action strategies were developed with strong emphasis on working in partnership with health-care authorities and providers. Follow-up workshops are planned in all WHO Regions during 2006 and 2007.

During 2005, Patients for Patient Safety has grown both in size and strength. Through a growing network of patient champions, the foundations for active patient involvement in patient safety issues around the world are being laid. During 2006 and 2007, Patients for Patient Safety will:

1. Continue to build a strong and respected international network of champions for patient safety through a series of regional workshops;
2. Develop and disseminate advocacy and communication resources and tools to support the work of these networks;
3. Promote strong patient involvement throughout the entire Forward Programme of the Alliance.



#### **Susan Sheridan, Leader, Patients for Patient Safety**

Patients for Patient Safety believes that the perspective, the wisdom and the will of patients and families from around the world provides THE most powerful contribution to ensuring a truly authentic and sustainable transformation in patient safety.





## LONDON DECLARATION

### **Patients for Patient Safety WHO World Alliance for Patient Safety**

**We**, Patients for Patient Safety, envision a different world in which healthcare errors are not harming people. We are partners in the effort to prevent all avoidable harm in healthcare. Risk and uncertainty are constant companions. So we come together in dialogue, participating in care with providers. We unite our strength as advocates for care without harm in the developing as well as the developed world.

**We** are committed to spread the word from person to person, town to town, country to country. There is a right to safe healthcare and we will not let the current culture of error and denial, continue. We call for honesty, openness and transparency. We will make the reduction of healthcare errors a basic human right that preserves life around the world.

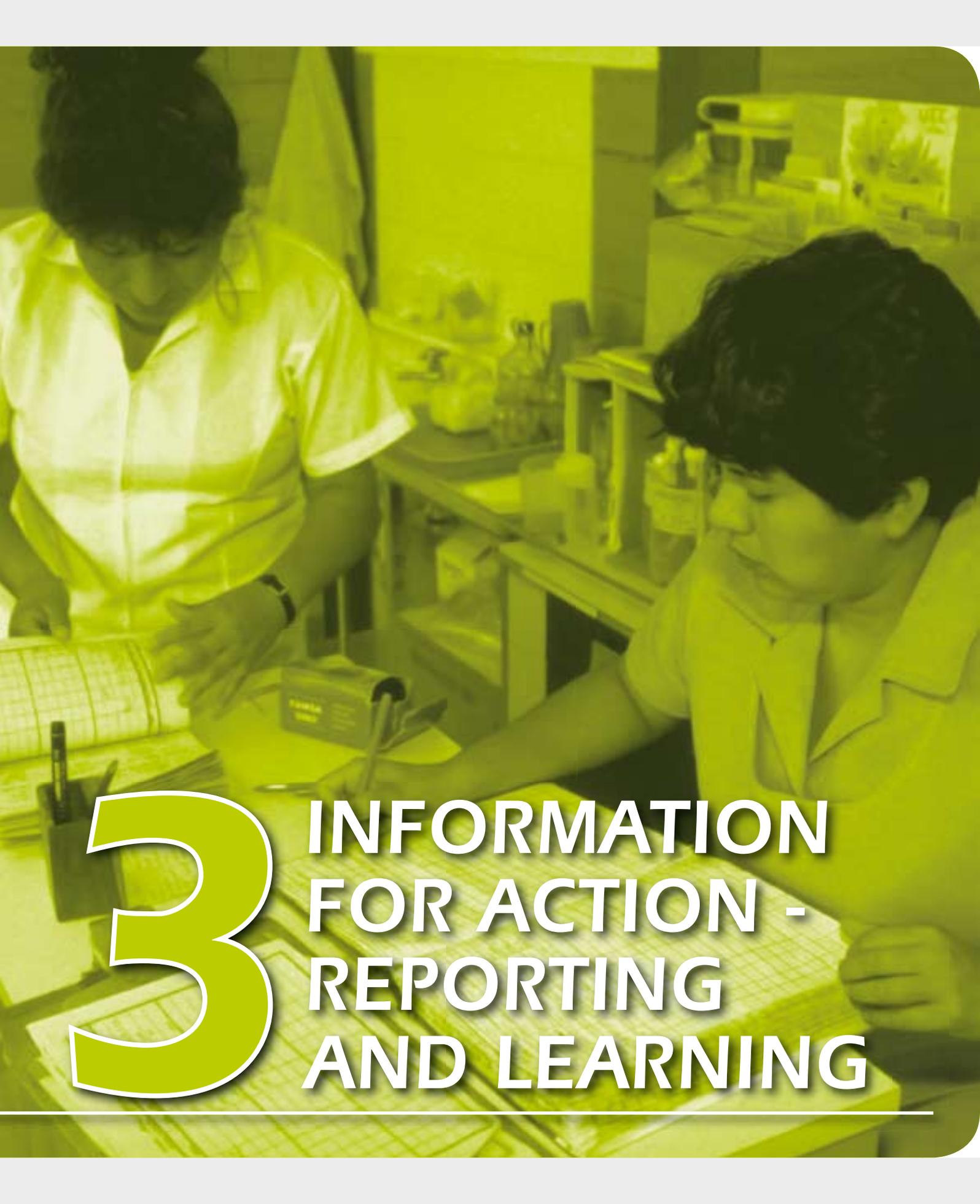
**We**, Patients for Patient Safety, will be the voice for all people, but especially those who are now unheard. Together as partners, we will collaborate in:

- Devising and promoting programs for patient safety and patient empowerment.
- Developing and driving a constructive dialogue with all partners concerned with patient safety.
- Establishing systems for reporting and dealing with healthcare harm on a worldwide basis.
- Defining best practices in dealing with healthcare harm of all kinds and promoting those practices throughout the world.

In honor of those who have died, those left disabled, our loved ones today and the world's children yet to be born, we will strive for excellence, so that all involved in healthcare are as safe as possible as soon as possible. This is our pledge of partnership.

*March 29, 2006*





3

INFORMATION  
FOR ACTION -  
REPORTING  
AND LEARNING

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Safety cannot be improved without a range of valid reporting, analytical and investigative tools that identify sources and causes of risk in ways that promote learning and preventative action.

Too often, health-care organizations fail to learn from their mistakes. Neither health-care providers nor health-care organizations advise others when a mishap occurs, nor do they always share what they have learned. As a consequence, the same mistakes are repeated and patients continue to be harmed by preventable errors.

Patient safety reporting systems — within health-care organizations, regionally and nationally

— are emerging as a major tool to help identify patient safety problems and provide data for organizational and system learning. The fundamental role of these systems is to enhance patient safety by learning from failures of the health-care system.

During 2005, the Alliance has worked closely with Professor Lucian Leape from the Harvard School of Public Health to produce the WHO Draft Guidelines for Adverse Event Reporting and Learning Systems. Launched in November 2005, the Guidelines introduce patient safety reporting with a view to helping countries develop or improve reporting and learning systems, in order to improve the safety of patient care. The Guidelines provide a comprehensive review of literature about reporting systems and a survey of countries with existing national reporting systems. They also make recommendations on issues for Member States to consider when developing or improving patient safety reporting systems.

Ultimately, it is the action taken in response to detecting problems that leads to change. It is important to note that reporting - or for that matter any system for detecting problems - does not in itself improve safety. It is the response adopted that leads to change.

Although reporting is a fundamental way of detecting risks, hazards and events, on its own it can never give a complete picture of all sources of risk and patient harm. A multi-faceted approach is therefore needed, incorporating methods such as reporting systems, audit of medical records, pooling and analysis of the findings of incident investigations, pro-active risk assessment tools and observational tools for error identification and improvement.

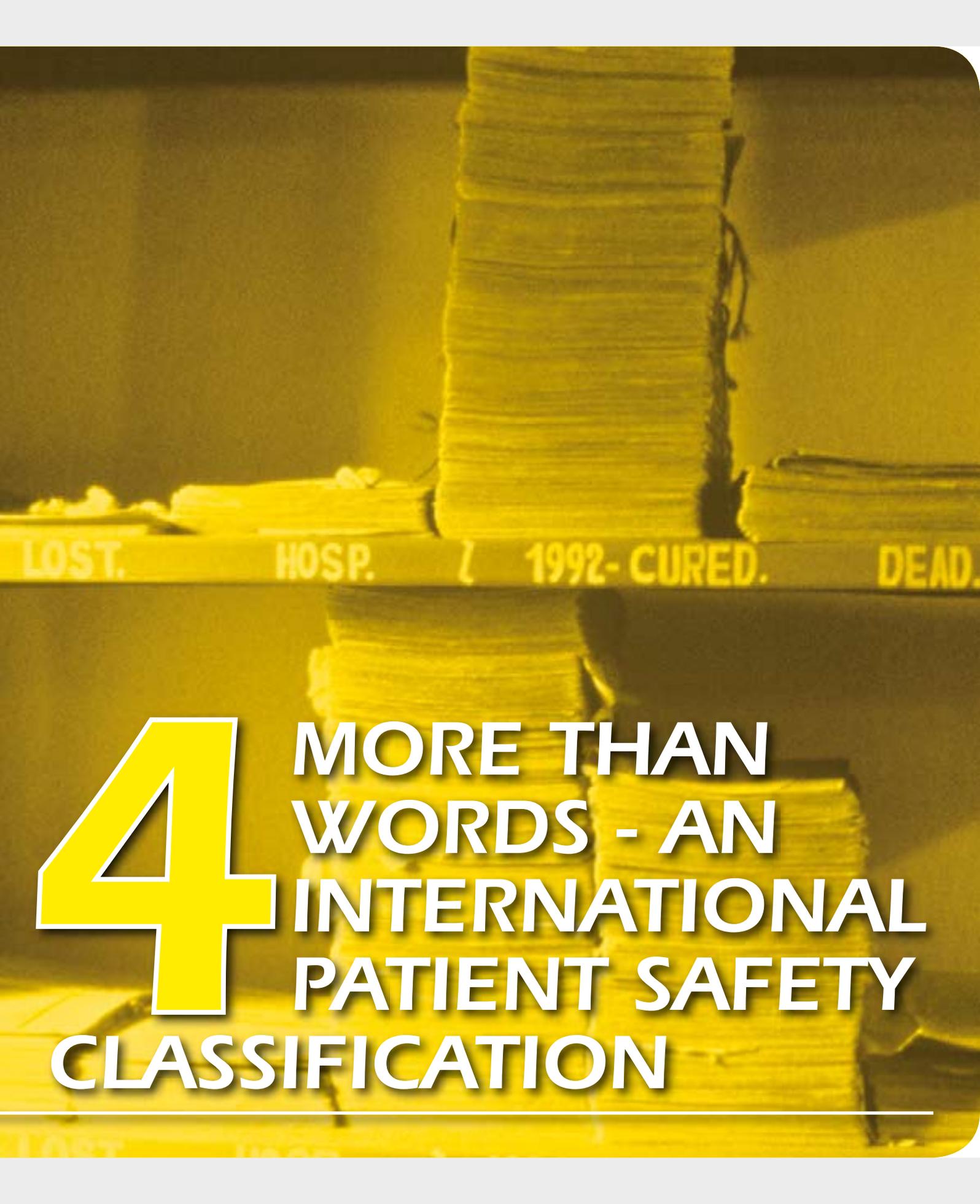
During 2006 and 2007, the Alliance will:

1. Consult on the recommendations outlined in the WHO Draft Guidelines for Adverse Event Reporting and Learning Systems, with a view to finalizing the Guidelines during 2007;
2. Identify and share leading developments in reporting and learning internationally, so that knowledge is available globally to interested Member States developing their own approaches;
3. Consult with experts on new approaches to reporting and learning which draw on multiple methods for detecting and analysing patient safety problems and learning;
4. Take forward pilot work to collect and analyse information about adverse incidents related to drug prescribing, dispensing and administration, in conjunction with the WHO Foundation Collaborating Centre for International Drug Monitoring.



### **Professor Lucian Leape**

One of the most frustrating aspects of patient safety is the apparent inability of health-care systems to learn from their mistakes. Tragic errors recur in new places over and over again. The solution to this problem is to investigate our errors and share lessons learned through a reporting system. The WHO Draft Guidelines for Adverse Event Reporting and Learning Systems provides the conceptual background information and practical advice for those who want to establish or improve a national reporting and learning system.



LOST.

HOSP.

1992-CURED.

DEAD.

# **4** MORE THAN WORDS - AN INTERNATIONAL PATIENT SAFETY CLASSIFICATION

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Improving patient safety requires better information-sharing about the number, types, causes and consequences of errors and adverse events.

Currently, there is no agreed classification system for patient safety data and multiple approaches have been developed, each serving different purposes. There is considerable variation in the approaches being used and little integration. This limits our capacity to promote international learning and makes comparison between countries complex, cumbersome and inaccurate.

The action area, Taxonomy for Patient Safety, aims to define, harmonize and group patient safety concepts into a classification that will elicit, capture and analyse factors relevant to patient safety in a manner conducive to learning and system improvement. This will be done in an adaptable, yet consistent way, across the entire spectrum of health care and across cultures and languages. The final product will be known as the International Patient Safety Classification.

During 2006 and 2007, the Alliance will:

1. Finalize the development of a conceptual framework, concepts and terms to form the basis of an International Patient Safety Classification;
2. Undertake extensive testing and consultation on the draft conceptual framework and concepts;
3. Field-test the draft International Patient Safety Classification with interested Member States;
4. Link closely with developments around key international classifications, especially with those belonging to the WHO Family of International Classifications and the WHO Drug Dictionary.



**5 KNOWLEDGE IS THE ENEMY OF UNSAFE CARE - RESEARCH**

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Presently, there is a scarcity in most countries of systematic information on the extent of patient harm caused by health care. This is particularly the case in developing and transitional countries. For example, the rapid scaling up of antiretroviral therapy (ART) in the weakened health systems of many developing countries raises concerns around the safety of its administration. Research studies in these contexts will offer exceptional opportunities for advancing research tools and methodologies applied to “data-poor” environments, and contribute to the development of a local research capacity for patient safety.

The World Alliance research action area aims to facilitate the effective use of research findings to inform safer health care in all WHO Member States. Key to the effective implementation of the research agenda is establishing an effective dialogue with the main constituencies of patient safety research. A number of international experts are collaborating with the Alliance to develop and implement the research programme.

Specific areas of focus include:

- Supporting further research into the extent and nature of patient harm in developing and transitional country contexts;
- Strengthening the evidence base for developing new solutions and contributing towards the effective adoption of existing solutions;
- Facilitating the advancement of tools and methods of research, with special interest being given to overcoming the difficulties posed by data-poor environments;
- Promoting international exchange and sharing between practitioners, researchers and specialists in patient safety across the different WHO regions;
- Building international consensus and action on research priorities.

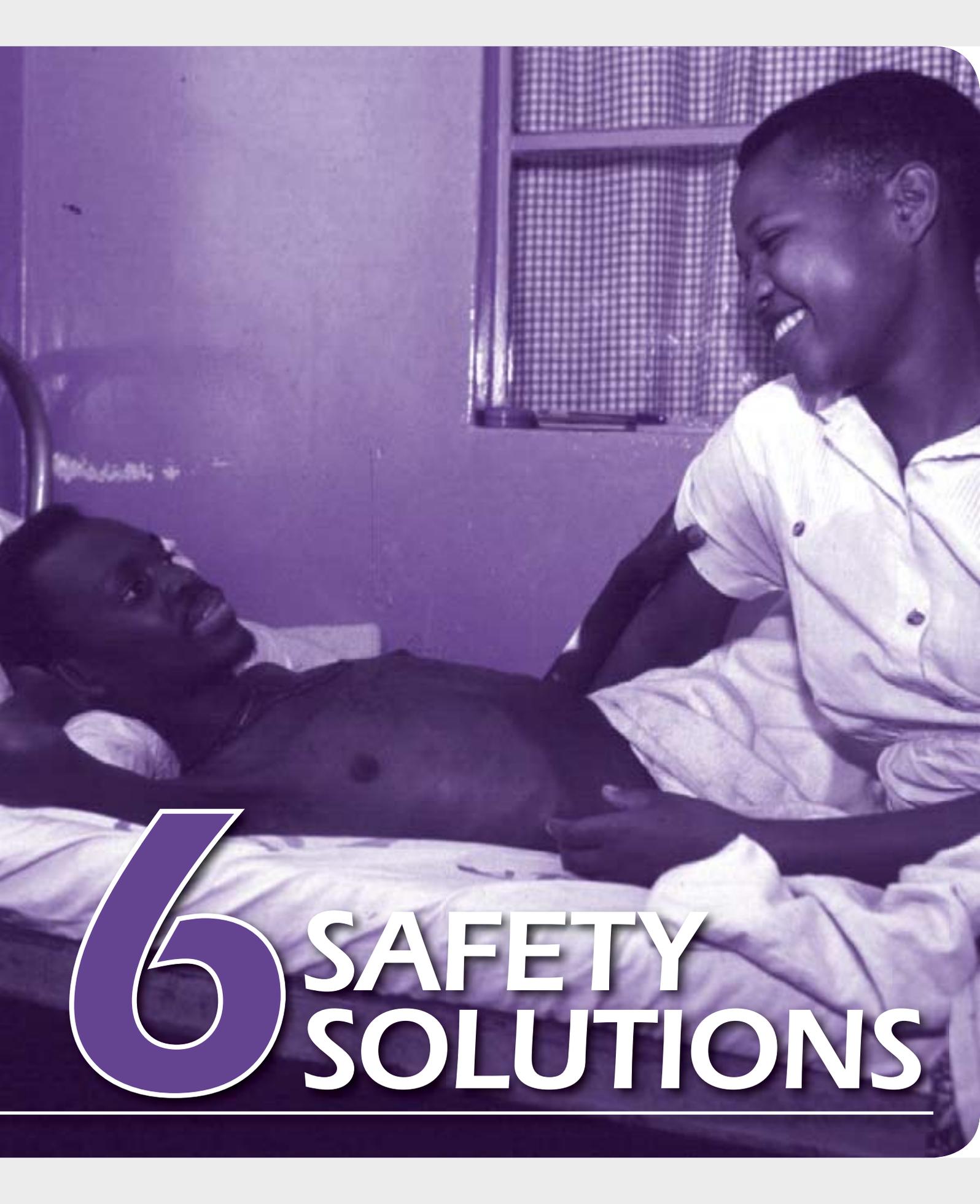
During 2006 and 2007 the Alliance will:

1. Coordinate research projects to identify the prevalence of adverse events in up to eight developing and transitional countries;
2. Commission studies on specific sources of patient safety risk in developing and transitional countries;
3. Establish an internationally agreed set of patient safety research priorities;
4. Establish effective governance arrangements through a Research Council and working groups.



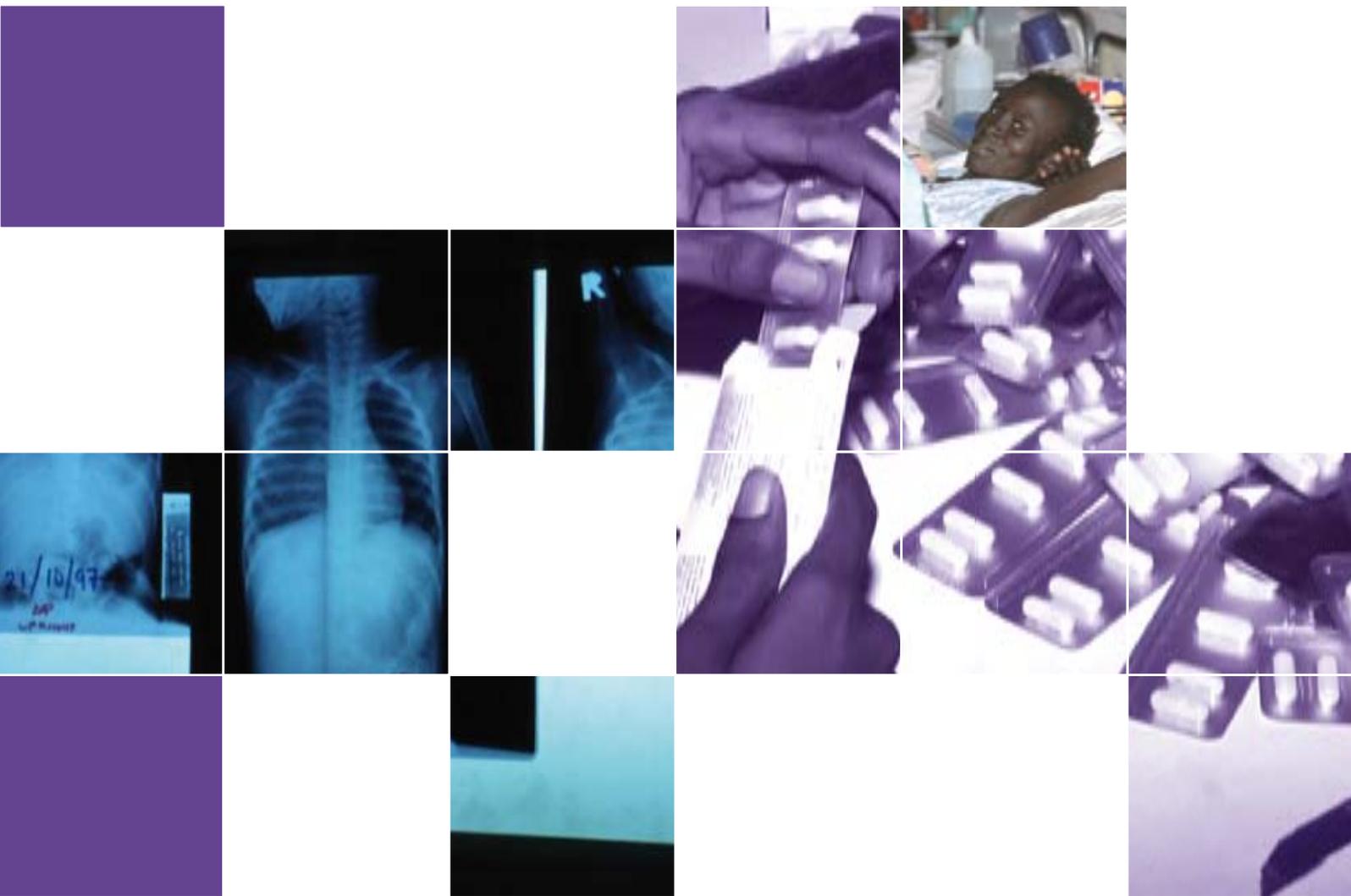
**Professor David Bates, playing a leading role in the research programme**

“The evidence now makes it clear that patient safety is a major issue in countries throughout the developed world. In most of the recent studies that have been done, about 10% of patients suffer an injury as the result of hospitalization. To date, we have much less information about patient safety in the developing world, but the existing data suggest that the problem is at least as big, though the issues differ by country. An early product of this program will be a number of studies to help define the problem in the developing world. But more broadly, the program will aim to define the patient safety research agenda in both the developing and developed worlds. In both, evaluation of the impact of interventions will undoubtedly be important.”



6

**SAFETY  
SOLUTIONS**



No adverse event should ever occur anywhere in the world if the knowledge exists to prevent it from happening. However, knowledge is of little use if it is not put into practice. With the proper planning, execution and mobilisation of knowledge and expertise, solutions can be applied to unsafe situations which will reliably and sustainably make them safer. Translating knowledge into practical solutions is the ultimate foundation of the safety solutions action area of the World Alliance for Patient Safety.

During 2005, the Joint Commission on Accreditation of Healthcare Organizations and Joint Commission International were officially designated as a WHO Collaborating Center on Patient Safety (Solutions). Since its launch in August 2005, the Collaborating Centre has commenced building an international network to identify, evaluate, adapt and disseminate safety solutions worldwide. The Collaborating Centre is identifying existing solutions that would be applicable to a wide variety of countries and health-care settings. Linkages are being created with key organizations and individuals with expertise in patient safety. These include accrediting bodies, national patient safety agencies, professional societies, and others.

Patient safety solutions are 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. Solutions disseminated by the Collaborating Centre will be evidence-based, presented in a standard format and will describe in simple terms what to do to address the risks associated with a particular safety problem. An individual solution will present the problem, the strength of evidence supporting the solution, adaptations for specific countries or world regions, potential barriers to adoption, risks of unintended consequences created by the solution, patient and family roles in the solution, and references and other resources.

#### **EXAMPLES OF SOLUTION TOPICS**

1. Universal wrong site surgery protocol
2. Look-alike, sound-alike medications
3. Medication reconciliation
4. High concentration medication solutions
5. Patient identification
6. Patient care hand-overs



In order to facilitate the accurate identification of solutions and the adaptation of solutions to different needs, regional advisory processes have been established. These will provide the basis for developing dissemination strategies and implementing them.

During 2006 and 2007, the Collaborating Centre will:

1. Develop, test and disseminate internationally at least six approved solutions using a standardized template;
2. Further develop a broad-based international collaborative network focused on patient safety solutions;
3. Convene an international steering committee composed of recognized leaders and experts in patient safety to select high priority solutions and approve final solutions for dissemination;
4. Convene Regional Advisory Groups to identify potential barriers to the adoption of high priority patient safety solutions in various countries and regions and modify solutions accordingly.

The Joint Commission and Joint Commission International are proud to be working with the World Alliance for Patient Safety to create a network of knowledge sharing about patient safety solutions. The Center intends to work with all parties of interest to make useful and needed patient safety solutions, both to those who provide patient care and those who are the recipients of that care. We are deeply committed to the World Alliance's objectives and believe the Collaborating Center will play a pivotal role in advancing its objectives.

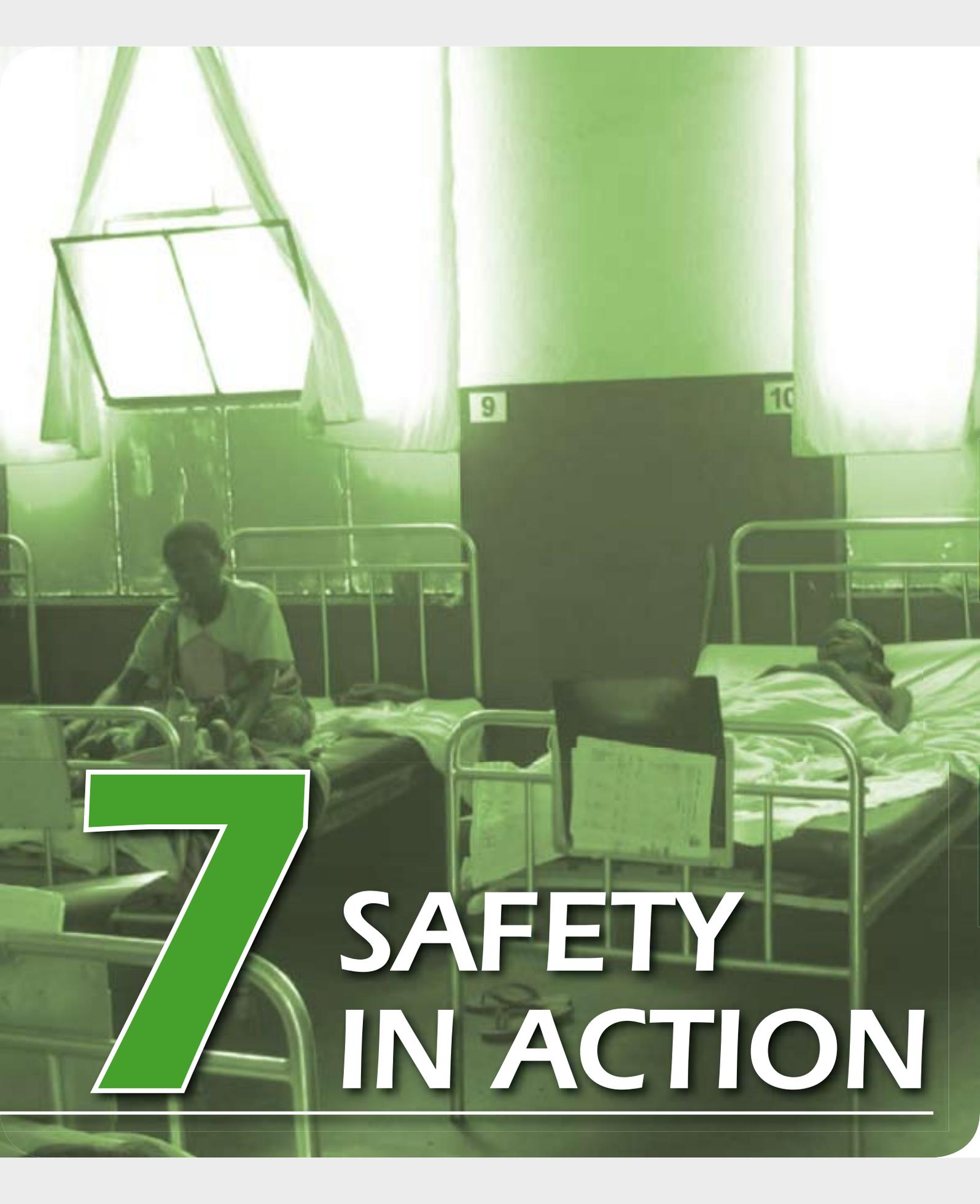


**Dennis S. O'Leary, M.D., President, Joint Commission on Accreditation of Healthcare Organizations**



**Karen H. Timmons, President & CEO, Joint Commission International**





**7**

**SAFETY  
IN ACTION**



Improving the safety of patient care requires health-care organizations, practitioners and policy-makers to come to terms with three important and inter-related groups of questions.

- Firstly, what is the right thing to do? Which practices improve safety? What is the evidence?
- Secondly, how do we do the right thing? What changes in our procedures and systems are needed to implement the new practice?
- Thirdly, how do we make sure that the right thing is done 100% of the time?<sup>3</sup>

The challenge of how best to ensure the timely and sustained implementation of changes in organizational, team and clinical practices to improve patient safety is a major area of focus for the World Alliance for Patient Safety.

Case studies of major adverse events reveal that action to reduce potentially fatal risks to future patients is often not clearly focused, organized or quick enough. This contrasts markedly with aviation and other high-risk industries in which such action is systematic, timely and concerted.

Two new initiatives are planned to further develop effective approaches to implement improved safety practices. These are known as *Action on Patient Safety* and *Patient Safety at the Leading Edge*.

### **ACTION ON PATIENT SAFETY**

The *Action on Patient Safety* project aims to learn from the systematic implementation of solutions of between five and seven major patient safety problems in five years in at least seven countries. In the first instance, it is proposed that this initiative builds upon the long history of partnership and cooperation of a number of countries through The Commonwealth Fund.

Through promoting the adaptation and uptake of solutions to major patient safety problems across the participating countries, the *Action on Patient Safety* initiative aims to demonstrate that these solutions have been effectively implemented within each country. In doing so, there will also be valuable lessons for the development and dissemination of patient safety solutions through the ongoing work of the WHO Collaborating Center on Patient Safety (Solutions).

Clearly, from a global perspective, ensuring the implementation of these solutions in a small number of countries is not sufficient. Over time, this initiative will therefore also work to encourage the seven countries to use their existing partnerships with other nations, particularly developing countries, to support the adaptation and implementation of the solutions within at least one country in the developing world.

Through this method, it is envisaged that the global implementation of a patient safety agenda will be catalysed and that patients in both developed and developing countries will benefit from shared learning and support.



During 2006 and 2007, the World Alliance will:

- Work in partnership with The Commonwealth Fund and the WHO Collaborating Center on Patient Safety (Solutions) to develop and implement an action plan with participating countries;
- Develop an action plan for partnership with other interested countries.

## **PATIENT SAFETY AT THE LEADING EDGE**

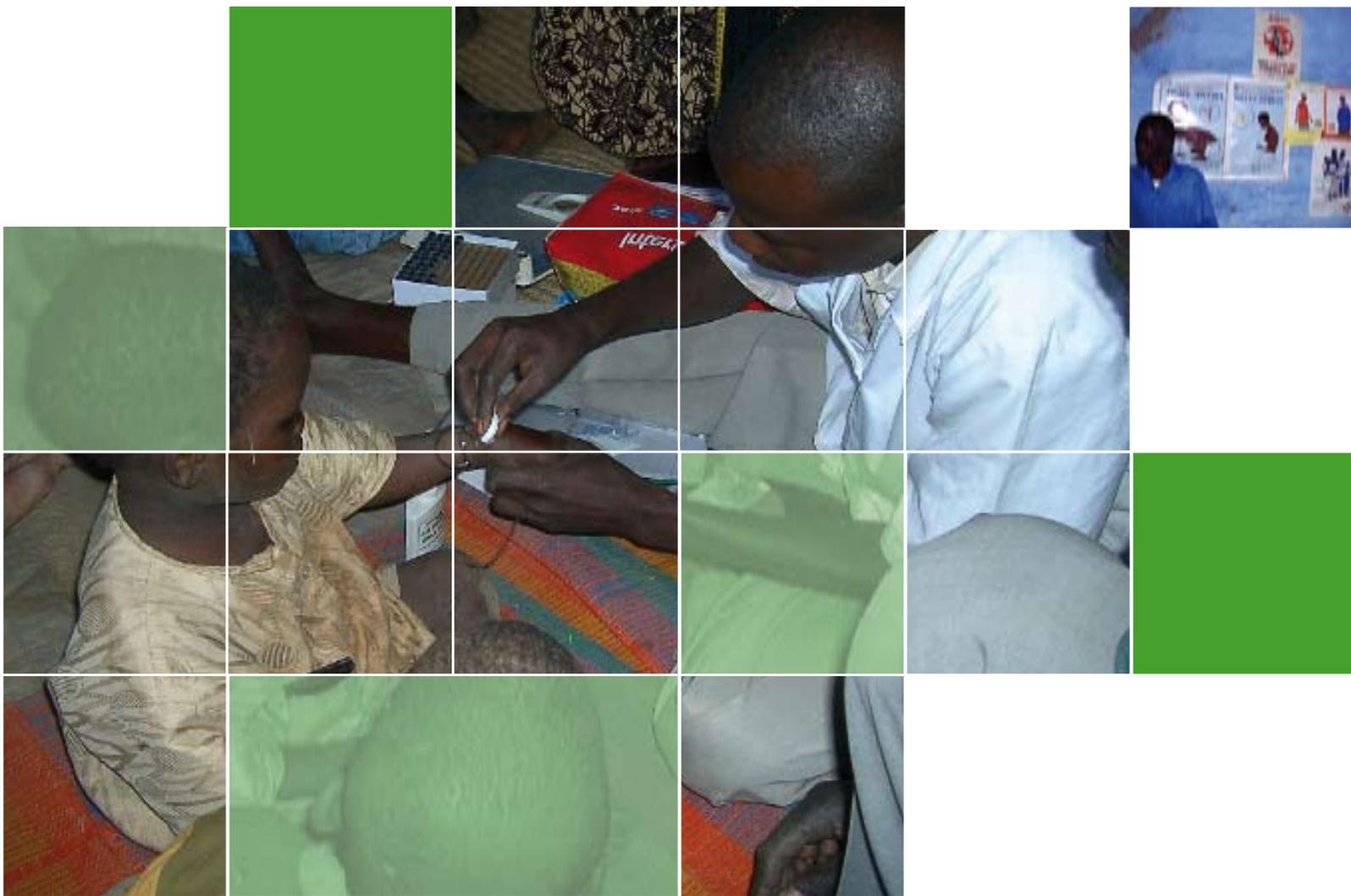
There are many examples worldwide of organisations and best practices from which we can be inspired and learn. For example, there are health-care organizations in very varied country contexts that have implemented innovative and successful strategies and programmes to improve patient safety. Their experience has tended to show that an organisational culture which promotes safety has certain distinct and consistent characteristics.

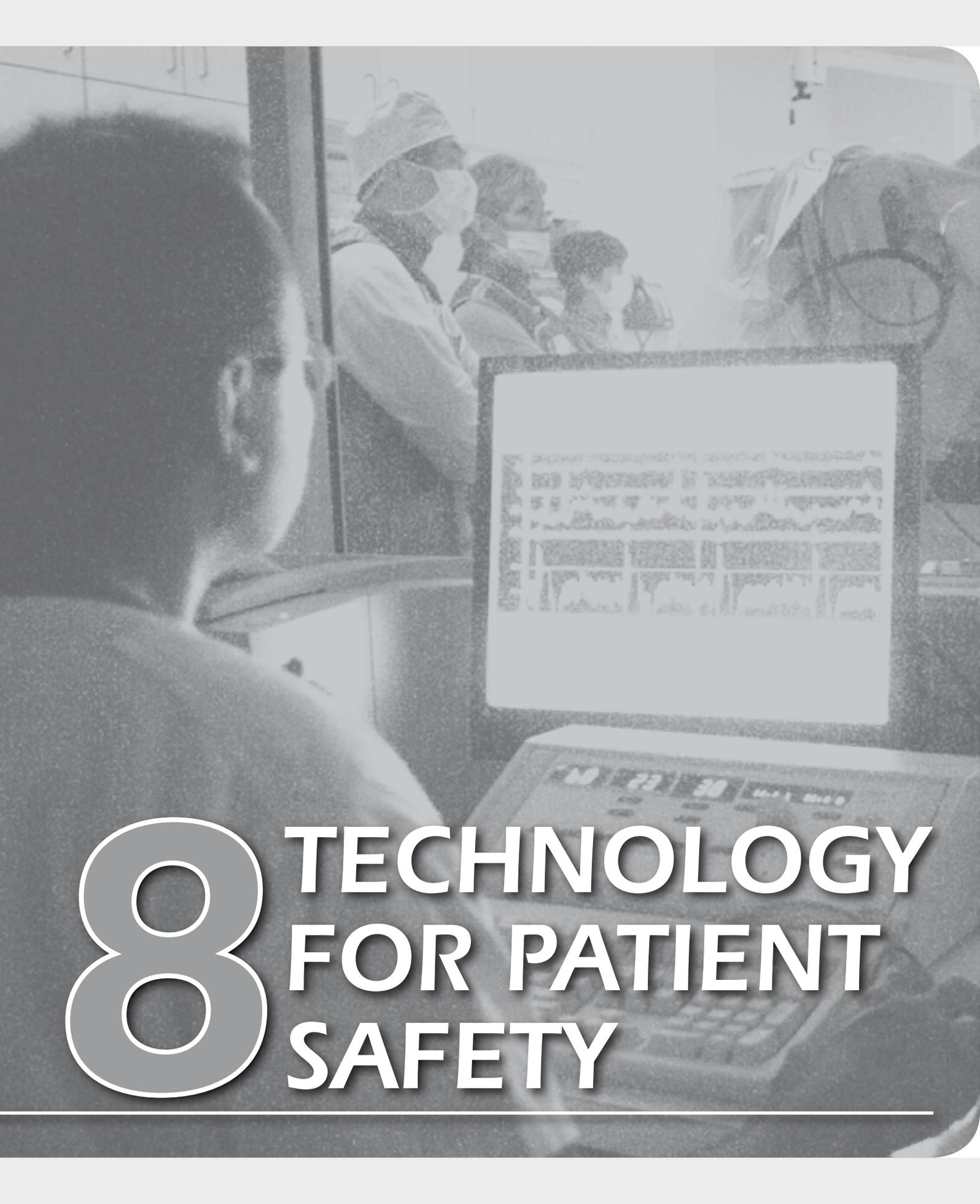
The World Alliance for Patient Safety aims to learn from the experience of these exemplar institutions and share this knowledge internationally. Key areas of interest include:

- the role of organizational leaders in establishing a strong culture of safety;
- strategies to promote buy-in from frontline health-care workers;
- team work;
- knowledge, skills and attitudes required of staff;
- partnerships with patients and their families;
- approaches to detecting problems and measuring changes;
- dissemination of lessons to health-care organizations.

During 2006 and 2007, the Alliance will:

1. identify health-care organizations with a track record in patient safety from around the world using an agreed methodology;
2. consult with those organizations on the main ingredients of their approach to patient safety;
3. collate and share these experiences with others and integrate this learning into all aspects of the Alliance's work.





**8**

**TECHNOLOGY  
FOR PATIENT  
SAFETY**

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Technology has the potential for being a powerful tool for improving patient safety. There are opportunities in terms of the effective implementation of information technology. There are also opportunities to adapt technology to improve equipment and facility design and use.

The future global potential of information technology for improving safety is huge but hard to estimate currently. The World Alliance for Patient Safety will contribute to this developing agenda by ensuring that this action area focuses on the opportunity for new technology to improve patient safety, with appropriate regard being given to the complexity and challenges of effective implementation and maximizing the cost benefit of investment.

Potential areas of interest include:

- Applying simulation methods to improve clinical skills, teamwork and communication;
- Identifying priorities for research in technology for patient safety;
- Reviewing and demonstrating the safety benefits of technology investment;
- Identifying how to overcome challenges to implementation.

During 2006 and 2007 the Alliance will:

1. consult with key experts on the opportunities to promote the effective use of technology as a tool to improve patient safety, with a particular focus on the full spectrum of simulation methods;
2. identify areas where the Alliance can best contribute to this emerging field of knowledge.

#### **SOME POTENTIAL PATIENT SAFETY BENEFITS OF TECHNOLOGY**

- Improved communication: getting the right information to the right people at the right time to make the right and safe decisions;
- Clinical decision support systems such as prompts, alerts, range settings, automated surveillance and use of robotics;
- Greater use of simulation technologies as part of education and training programmes and effective team working;
- Technology to improve the design and safety of health-care processes such as electronic health care records and patient identification systems;
- Medication safety management including computerized order entry systems;
- Smart pumps and smart monitoring;
- Computerized notification, monitoring and tracking of critical and abnormal test results;
- Facilitating the routine assessment of safety and the recording of errors and harm.



**9** **INTERNATIONAL  
PARTNERSHIP FOR  
CARE OF ACUTELY  
ILL PATIENTS**

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Safe care of the acutely ill patient is a major challenge for health services worldwide. As a consequence, the World Alliance for Patient Safety will address this challenge in its programme named “International Partnership for the Care of Acutely Ill Patients”.

The care of acutely ill and emergency patients is a central component of many health services, but often fails to be recognized as such because the treatment is delivered by separate medical specialities, each focusing on elective treatment. Rapidly changing acute diseases can become life-threatening if they are not treated promptly and appropriately. Risks of error in this context are increased by discontinuities and gaps in care caused by service pressures, shift work and staffing constraints. These problems are common to all health-care systems, including the most affluent; resource-poor settings in developing and transitional countries will suffer disproportionately from the burden of acute care, and are therefore particularly important partners in this programme.

Improving the safety of acutely ill patients requires integration of care throughout the entire patient journey. Integration at a local level needs to be supported by trans-disciplinary integration of stakeholder organizations across national boundaries.

In collaboration with the World Alliance, the International Partnership for Acute Care Safety (IPACS) will bring together organizations and individuals worldwide with an interest in acute care, including patient groups, health-care management and industry, in order to develop an internationally agreed approach to supporting and initiating research, educating and disseminating best practices in acute care. This focus on the acutely ill patient will bring improvements to patient safety across the whole spectrum of health care.

During 2006 and 2007, the World Alliance will:

- Co-host a meeting with the International Partnership for Acute Care Safety to identify key patient safety priorities and develop an action plan.



**10** PATIENT SAFETY  
KNOWLEDGE AT  
YOUR FINGERTIPS

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What are the major challenges for patient safety globally? What action can be taken to address these challenges? Where are some of the best examples of successful patient safety programmes? What should patients, health-care professionals, leaders and managers do? What can be done to increase the knowledge and actions needed to improve patient safety?

Providing answers to these questions will form the basis of a programme to develop and share knowledge on patient safety issues and to report globally.

During 2006 and 2007, the World Alliance for Patient Safety aims to work with Member States and partners to gather, share and report knowledge on patient safety developments across the world addressing areas such as:

- initiatives and programmes underway in Member States and regions;
- reporting on the progress of the work of the Alliance;
- focusing on specific and important patient safety topics;
- reviewing learning and significant safety issues from other industries, academic study and research findings;
- reporting on available patient safety data;
- gathering stories of patient experiences.

# WORLD ALLIANCE *for* PATIENT SAFETY



World Health  
Organization

# 11

## GOVERNANCE AND PROGRAMME SUPPORT



The World Alliance for Patient Safety is managed by a Secretariat, the WHO Patient Safety Programme, based within WHO headquarters in Geneva, Switzerland and London, England. The Secretariat is complemented by regional patient safety focal points in all WHO Regional Offices.

The Alliance has established a number of advisory committees to advise on the planning, design and implementation of its work programme. The Alliance has actively encouraged the involvement and contribution of patient safety leaders in Alliance programmes and expert groups. During 2006 and 2007, a particular emphasis is being placed on engaging nursing and other professional leaders from around the world. Effective links have also been established with a range of stakeholders from all parts of the world.

Each Alliance programme has a detailed project plan with specific objectives to be achieved within a specified timescale. The Secretariat closely monitors the delivery of each programme. Progress is communicated on a regular basis through the WHO web site — [www.who.int/patientsafety](http://www.who.int/patientsafety).

Funding for the Alliance is allocated through WHO. The Alliance receives its core funding through a five year donor agreement with the Department of Health in the United Kingdom. This is complemented by resources and in-service support from other Member States, industry and foundations.

## **PARTNERSHIP ENGAGEMENT**

The World Alliance for Patient Safety is working towards raising political commitment and knowledge for improving the safety of care. The Alliance helps to strengthen partnerships and networks of agencies, associations, patient groups, health authorities and technical experts, to build on the knowledge of what works best and align global advances in patient safety with existing efforts within countries.

## **WORKING WITH MEMBER STATES**

The World Alliance for Patient Safety will continue to encourage and support the collaboration, development and implementation of patient safety programmes in WHO Member States in collaboration with the Regional Offices of WHO.

The Alliance implements the work of its 10 action areas in a flexible and non-prescriptive way, recognizing the diversity of country, health, and economic situations and taking into account priorities, opportunities and obstacles unique to each setting.

The Alliance holds an annual Alliance Day to review progress and to discuss proposals for new programmes. The meeting is held in a different WHO region each year. This also provides an opportunity to highlight patient safety challenges and advances in Member States in the host region.



WORLD ALLIANCE  
for  
PATIENT SAFETY

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Caring. Caring. safer. Care.

WORLD ALLIANCE  
for  
PATIENT SAFETY

Patients for  
Patient Safety

WORLD ALLIANCE  
for  
PATIENT SAFETY  
Research  
to improve patient safety

# FROM OUR PARTNERS



### **International Hospital Federation**

The International Hospital Federation (IHF) is proud to partner with WHO through the World Alliance for Patient Safety. IHF has addressed the issue of patient safety at our events, in our publications and at our Governing Council meetings. It is commonly agreed at IHF that patient safety should be high on the agenda of health service organizations in all countries, both developing and developed. This is a matter that should unite us in action across borders of all kinds, countries as well as professions, private as well as public services. But let us not use words only, let us act!"

**Professor Per-Gunnar Svensson**

Director General  
International Hospital Federation



### **The World Medical Association**

Individuals and processes are rarely solely responsible for producing errors. Rather, separate elements combine and together produce a high-risk situation. Therefore, there should be a non-punitive culture for confidential reporting of healthcare errors that focuses on preventing and correcting systems failures and not on individual or organization culpability.

A realistic understanding of the risks inherent in modern medicine requires that physicians go beyond the professional boundaries of health care and cooperate with all relevant parties, including patients, to adopt a proactive systems approach to patient safety."

**Otmar Kloiber**

Secretary General  
The World Medical Association



### **The International Pharmaceutical Federation**

As a representative of over one million pharmacists world-wide, the International Pharmaceutical Federation (FIP) is greatly committed to the promotion of patient safety around the globe. Medication use in all facets of the population has grown to become as widespread as the basic notion of health care itself, and as highly educated specialists in all aspects of medication provision and use, pharmacists are at the forefront of improving patient safety within this and associated realms of healthcare. By initiating the FIP Patient Safety Working Group in 2004, and by partnering with key stakeholders such as the World Alliance for Patient Safety, FIP strives for the active advocacy of safe health care delivery, and in turn aims to make a significant contribution to remedying this threat to the welfare of the global community.

**A.J.Hoek**

General Secretary and Chief Executive Officer  
International Pharmaceutical Association



### **The International Council of Nurses**

The International Council of Nurses have been an active partner in the work so far and are particularly pleased to note the focus on making a fundamental difference to the patient experience through tackling issues, like hand hygiene, which relates to all health workers and indeed patients, relatives and the wider public.

ICN welcomes the report and pledges to continue to work with WHO, key stakeholders and our member associations to further protect those that we as nurses care for. Nurses have a key role to play in tackling these issues and therefore must be fully involved operationally and strategically in local, national, regional and global fora.

### **Extract from the ICN Intervention at the 59th World Health Assembly** (Agenda item 11.16 – Patient Safety)



### **The Association for Professionals in Infection Control and Epidemiology (APIC)**

The Association for Professionals in Infection Control and Epidemiology (APIC) fully support the Global Patient Safety Challenge: Clean Care is Safer Care. As patient safety advocates, our members are committed to reducing the occurrence of healthcare-associated infections (HAIs) by improving hand hygiene practices among health care providers and patients. We stand beside WHO in support of patient safety initiatives that will reduce HAIs.

**Kathleen Meehan Arias,**  
MS, CIC  
2006 President  
Association for Professionals in Infection Control and Epidemiology (APIC).

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