



Patients' Safety Project

M.A. Hamandi



Patients

DEAD 1999
KEVIN MURPHY
Age: 21 years old
Place: IRELAND
Cause: Failure to detect an excessively high blood calcium level.
Source: Patient's family



HARMED 1994
URIEL GONZÁLEZ VÁZQUEZ
Place: MEXICO
Cause: Fetal distress and untreated neonatal jaundice causing brain damage.
Source: Perspectives in Health 2005, the Pan American Health Organization



DEAD 2002
PAT SHERIDAN
Age: 45 years old
Place: USA
Cause: Failure to communicate diagnosis of spinal cancer leading to delay in treatment. Cal, Pat's son, brain damaged due to untreated neonatal jaundice.
Source: Partnership for Patient Safety



DEAD 2001
Josie King
Age: 18 months
Place: USA
Cause: Severe dehydration during hospital stay



HARMED 1999
IAN KELLY
Age: 41 years old
Place: UNITED KINGDOM
Cause: Contracted MRSA (methicillin resistant Staphylococcus aureus) following routine leg operation. Four years later Ian remained ill and agreed to a through-the-knee amputation.
Source: Patient



DEAD 2001
WAYNE JOWETT
Age: 18 years old
Place: UNITED KINGDOM
Cause: A chemotherapy drug (vincristine) incorrectly administered into his spine instead of a vein.
Source: Patient's family





Adverse Events in Health Care

Some statistics

The problem of adverse events in health care is serious

- 10% of hospital patients suffer an adverse event each year (Europe studies)
- 16.6% of hospital patients suffer an adverse event (Australian study)
- 98,000 hospital deaths every year through medical error (USA)



Adverse Events in Health Care

Some statistics

The problem of adverse events in health care is serious

- 7-10% patients in ACS suffer adverse drug events
- 10% of hospital admissions (in some countries) are due to ADR
- OT (outcome) account for 50% of all adverse events
- Unsafe injections cause 1.3 m deaths/year

The problem of adverse events in health care is more serious in developing countries. Less data available



Some statistics on economic loss

- The economic impact of unsafe care is important:
 - UK: costs as high as US\$6 billion a year
 - USA: about US\$29 billion a year



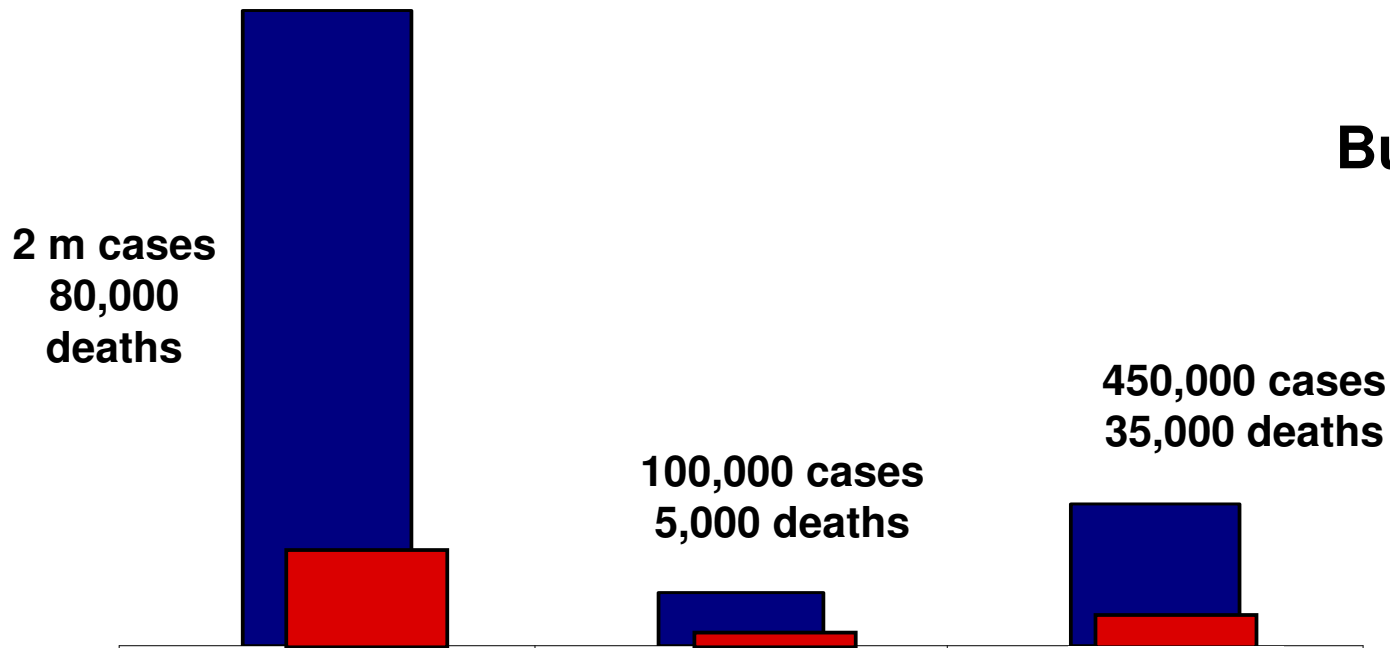
Health care-associated infection (HAI)

- **1.4 million people worldwide affected/ any given time**
- **5% -10% of hospital patients in developed countries**
- **2 to 20 times higher HAI risk in developing countries**
- **In some countries 25% of patients are affected**

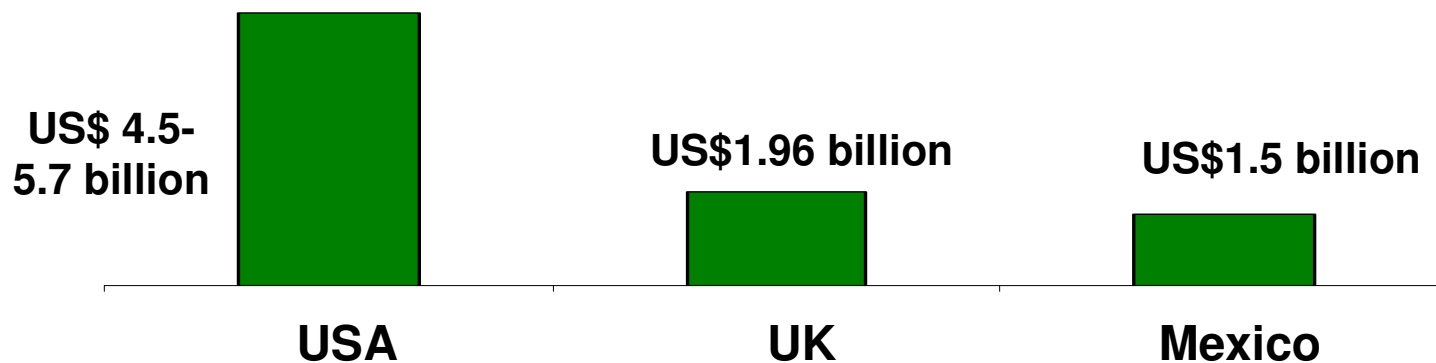


Health care-associated infection

Burden/year



Costs/year





World Alliance for Patient Safety

WHO's World Alliance for Patient Safety set up to address problem of Patient Safety in Member States



The Start

Susan Sheridan Story Who took the lead of the alliance





Susan Sheridan

Susan Sheridan became involved in patient safety after her family experienced two serious medical system failures. Her husband, Pat, died in 2002 after his diagnosis of spinal cancer failed to be communicated. Their son, Cal, suffered severe brain damage called kernicterus five days after his birth in 1995 when his neonatal jaundice was untreated.



Susan Sheridan

Susan is co-founder and past President of Parents of Infants and Children with Kernicterus (PICKS), which works in partnership with private and public health agencies to eradicate kernicterus.

In 2003, she co-founded Consumers Advancing Patient Safety, a non-profit organization that seeks a safe, compassionate and just healthcare system through proactive partnership between consumers and providers of care.



Susan Sheridan

In 2004, Susan was asked to lead the World Health Organization's Patients for Patient Safety initiative, one of several action areas of the World Alliance for Patient Safety. She is also a member of the Agency for Healthcare Research and Quality (AHRQ) Patient Safety Research Coordinating Center Steering Committee

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Patient safety

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Patient safety

In October 2004, WHO launched the World Alliance for Patient Safety in response to a World Health Assembly Resolution (2002) urging WHO and Member States to pay the closest possible attention to the problem of patient safety. The Alliance raises awareness and political commitment to improve the safety of care and facilitates the development of patient safety policy and practice in all WHO Member States. Each year, the Alliance delivers a number of programmes covering systemic and technical aspects to improve patient safety around the world.



Patient safety: Key issues

 Patient Safety interview of the month by Sir Liam Donaldson	 Clean Care is Safer Care: Country Campaigning Meeting	 Patient safety fact file
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PAST EVENTS

Second Technical Working Group Meeting - "Safe Surgery Saves Lives"
9-11 July 2007 - Geneva, Switzerland
[More information](#)

Regional Patient Safety Workshop on "Clean Care is Safer Care"

UPCOMING EVENTS

Patient Safety Research Shaping the Future in Geneva
24-26 September 2007 - Porto, Portugal
[More information](#)

[View all upcoming events](#)

ABOUT US

[World Alliance for Patient Safety](#)



PATIENT SAFETY NEWS

USA
June 2007
Sixth Quality Colloquium at Harvard University Announces Patient Safety Certificate Program
[More information](#)

USA
June 2007
Patients meet to promote mother and child health in the Americas
[More information](#)

France
May 2007
Patient safety activities: an overview
[More information \[pdf 66kb\]](#)

[News archive](#)

RIGHTS

Norway
National Unit for Patient Safety
[More information](#)

Institute for Healthcare Improvement

www.who.int/patientsafety



Overview of the Alliance

- **The Alliance:**
 - **Secretariat housed at WHO**
 - **Working in 10 action areas**
 - **Most programmes have an external technical lead**
 - **New areas of work planned for next biennium**



Overview of the Alliance

The Alliance :

- **Generates awareness and commitment: political, clinical, patient**
- **Engages global and regional partners: private, public, NGO**
- **Develops and shares knowledge: guidelines, standards, research data, solutions, reporting & learning**
- **Mobilises partners to support implementation of country projects.**



Partnerships

The Alliance works in partnerships with:

- **Governments** and health authorities of WHO Members State (GPSC, Solutions, Research)
- **International Alliances and organisations** (Commonwealth Fund, ICN, WMA, IHF, FIP, IAPO, IFIC, ISQua)
- **Patient Safety/Healthcare Associations/Agencies** (NPSA, DPSA, Agency for Healthcare Research and Quality –USA, the Australian Council for Safety and Quality of Care, Mexican Patient Safety program, Spanish Agencia de Calidad del Sistema Nacional de Salud, the Irish Health Services JCAHO –USA, and others)
- **NGOs** (Save the Children Fund, Intl Federation of Red Cross and Red Crescent Societies and others)
- **Universities and Research Institutes** (Harvard, John Hopkins, Imperial College London, and others)
- **National Patient Groups** and patient champions.



Six action areas 2005-2006

1. First Global Patient Safety Challenge: Clean Care is Safer Care

2. Patients for Patient Safety

3. Taxonomy



4. Research on patient safety

5. Reporting and learning

6. Solutions to improve patient safety



Progress

- **First Global Patient Safety Challenge: Clean Care is Safer Care** (http://www.who.int/patientsafety/events/05/global_challenge/en/index.html)
 - Development of the WHO Guidelines on Hand Hygiene in Health Care (Advanced Draft) and related tools
 - Launched the initiative in 55 countries, representing 74% world's population – will launch in about 10 more countries by end 2007
 - Pilot sites in 6 WHO regions testing implementation of WHO Guidelines
 - 40 Complimentary sites
- **Patient for Patient Safety** (http://www.who.int/patientsafety/patients_for_patient/en/)
 - 4 PFPS regional workshops on patient safety (Eastern Mediterranean, Americas, Europe and South East Asia)
 - Patient Safety Declaration in 2006
- **Taxonomy** (<http://www.who.int/patientsafety/taxonomy/en/>)
 - Developed the International Classification for Patient Safety (ICPS)
 - ICPS is being field tested



Progress

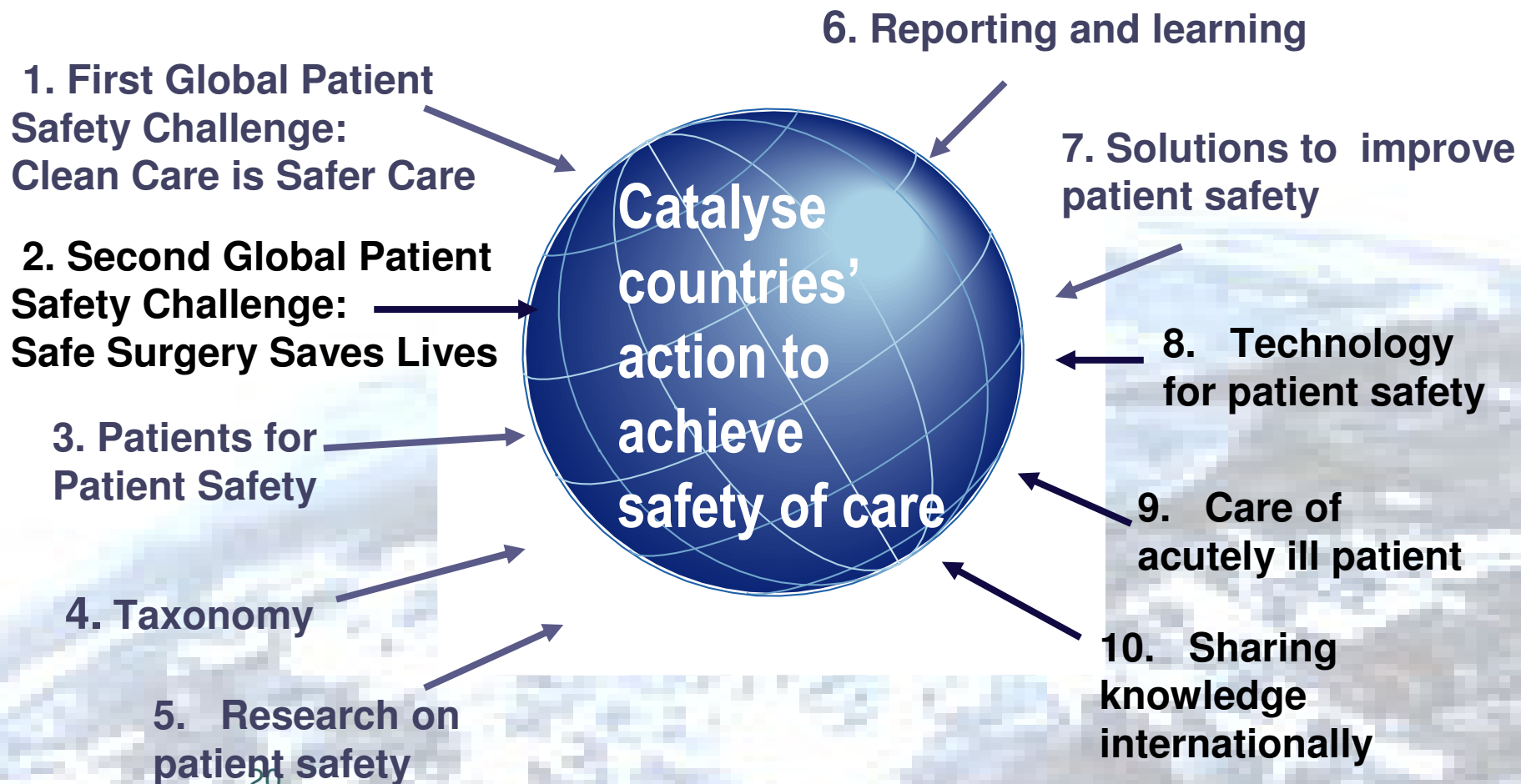
- **Research** (<http://www.who.int/patientsafety/research/en/>) 4 main areas:
 - Priority setting
 - Methods and measures
 - Strengthening capacity for research
 - Country research studies

- **Solutions** (<http://www.who.int/patientsafety/solutions/en/>)
 - Launch of 9 solutions for Patient Safety (May 2007)
(http://www.who.int/patientsafety/events/07/02_05_2007/en/index.html)

- **Reporting and Learning**
 - Launch of the WHO Draft Guidelines on Adverse Event Reporting and Learning systems
(http://www.who.int/patientsafety/reporting_and_learning/en/)



Ten action areas 2007-onwards





Progress

- **Safe Surgery Saves Lives**

(<http://www.who.int/patientsafety/challenge/safe.surgery/en/index.html>)

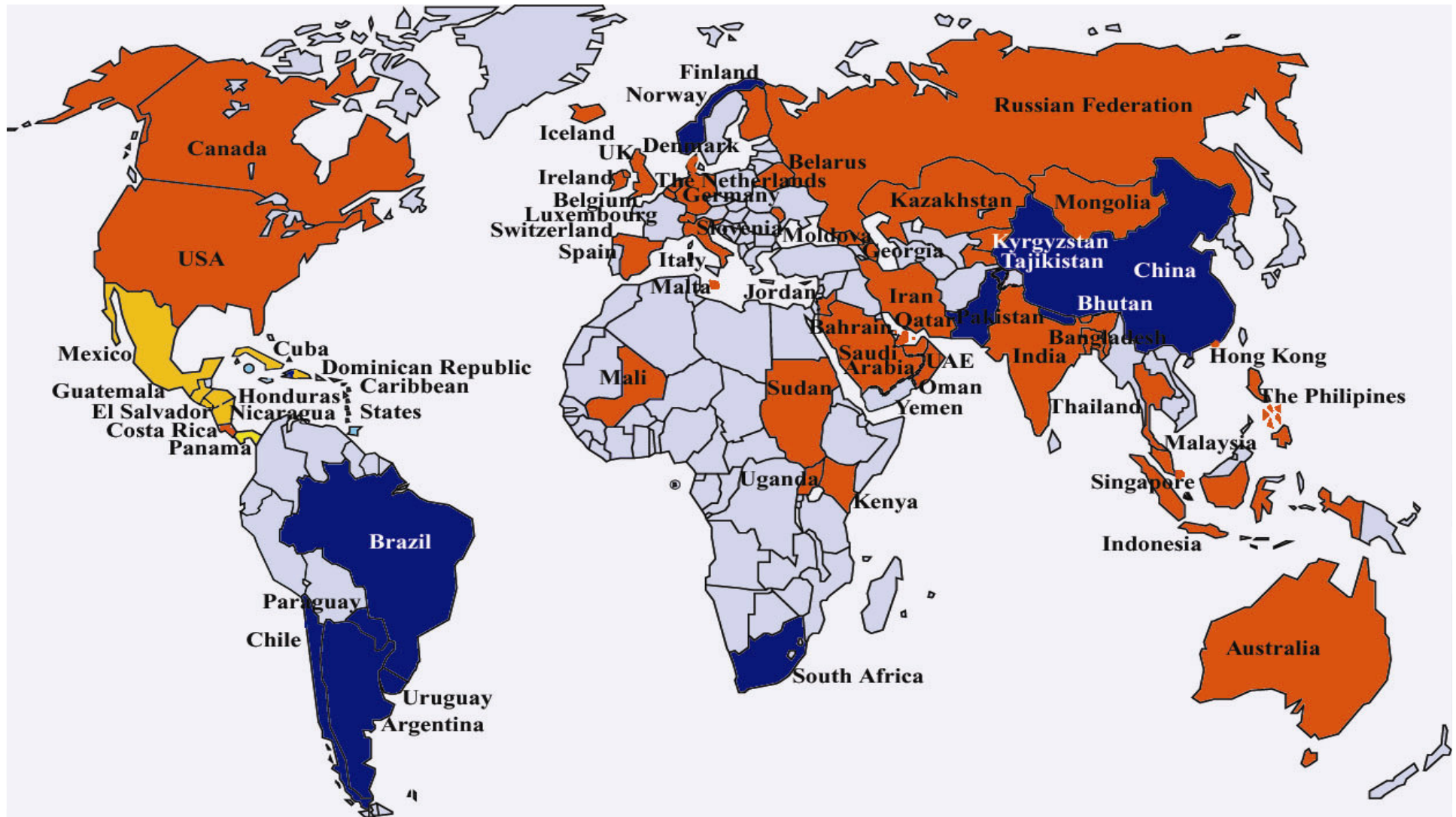
- Aims to improve the safety of surgical care around the world
- Development of a Checklist to reinforce safety practices
- 4 Working groups: Surgical Site Infection Prevention, Safe Anaesthesia, Safe Surgical Teams, and Measurement of Surgical Care

- **Care of acutely ill patient**

- In collaboration with the International Partnership for Acute Care Safety (IAPCS)



Countries committed to address HAI





Patients Safety Lebanon Project

- Project is a partnership between :





Objectives of the Project

- Improve the culture of safety in Lebanese hospitals
- Minimize adverse events as result of health care delivery
- Identify priority areas in patients safety
- Identify training needs in all aspects that affect the safety culture



Phase 1: Data collection/ needs assessment

A self administered questionnaire will be addressed to nurses in all hospitals in Lebanon inquiring about patients' safety culture.

The sample size is 12% of the number of beds yielding a total sample of 1,000.



Phase 1: Assessment

The survey results will be analyzed and deficiencies will be identified. As soon as the results of the survey are published, the Syndicate will have a role of disseminating the results to all stakeholders and through their webpage. In addition, they will be discussed in the Syndicate's Administrative Board to recommend appropriate actions.



Phase 2: Training

- Hospitals will be trained on how to address priorities found in the analysis.
- The magnitude of training depends largely on the results of the survey.. It will consist of training at least one person from each hospital to become a trainer for all staff.



Phase 3: Evaluation

The impact of the training will be evaluated by another survey.

The Syndicate will be involved in disseminating the results and recommending appropriate actions.



Conclusion

*Your Cooperation contributes
to patients' safety in
Lebanon*

Thank You