Patients' Safety Project

M.A. Hamandi

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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

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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)

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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 in more serious in developing countries. Less data available

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Some statistics on economic loss

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- The economic impact of unsafe care is important:

  - UK: costs as high as US$6 billion a year
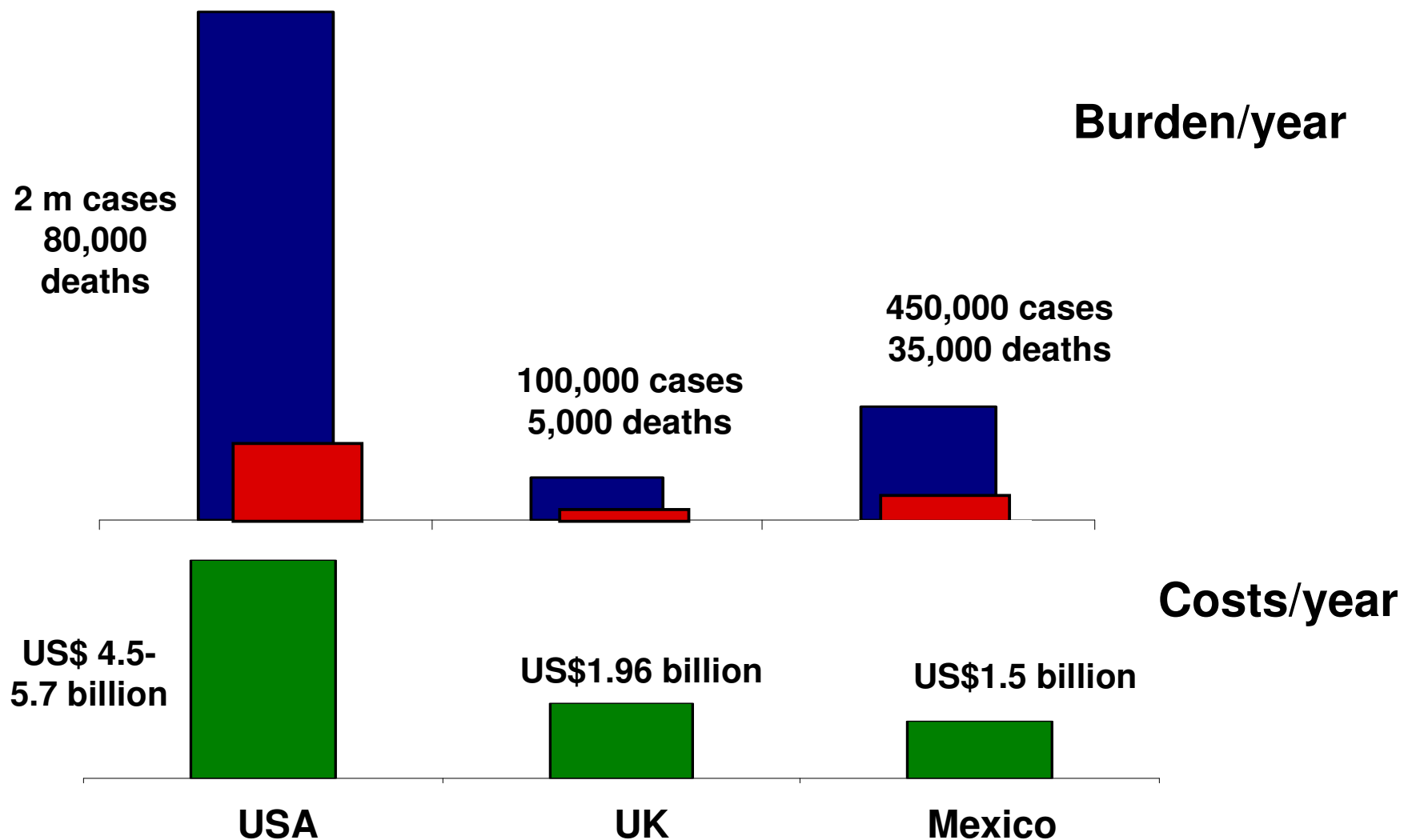 - USA: about US$29 billion a year

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

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

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The Start

Susan Sheridan Story Who took the lead of the alliance

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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.

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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

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.

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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

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 Agenda
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

HIGHLIGHTS

Norway
National Unit for Patient Safety
More information

Institute for Healthcare Improvement

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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**

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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.**

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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.

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Six action areas 2005-2006

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

2. **Patients for Patient Safety**

3. **Taxonomy**

Catalyse countries' action to achieve safety of care

4. **Research on patient safety**

5. **Reporting and learning**

6. **Solutions to improve patient safety**

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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
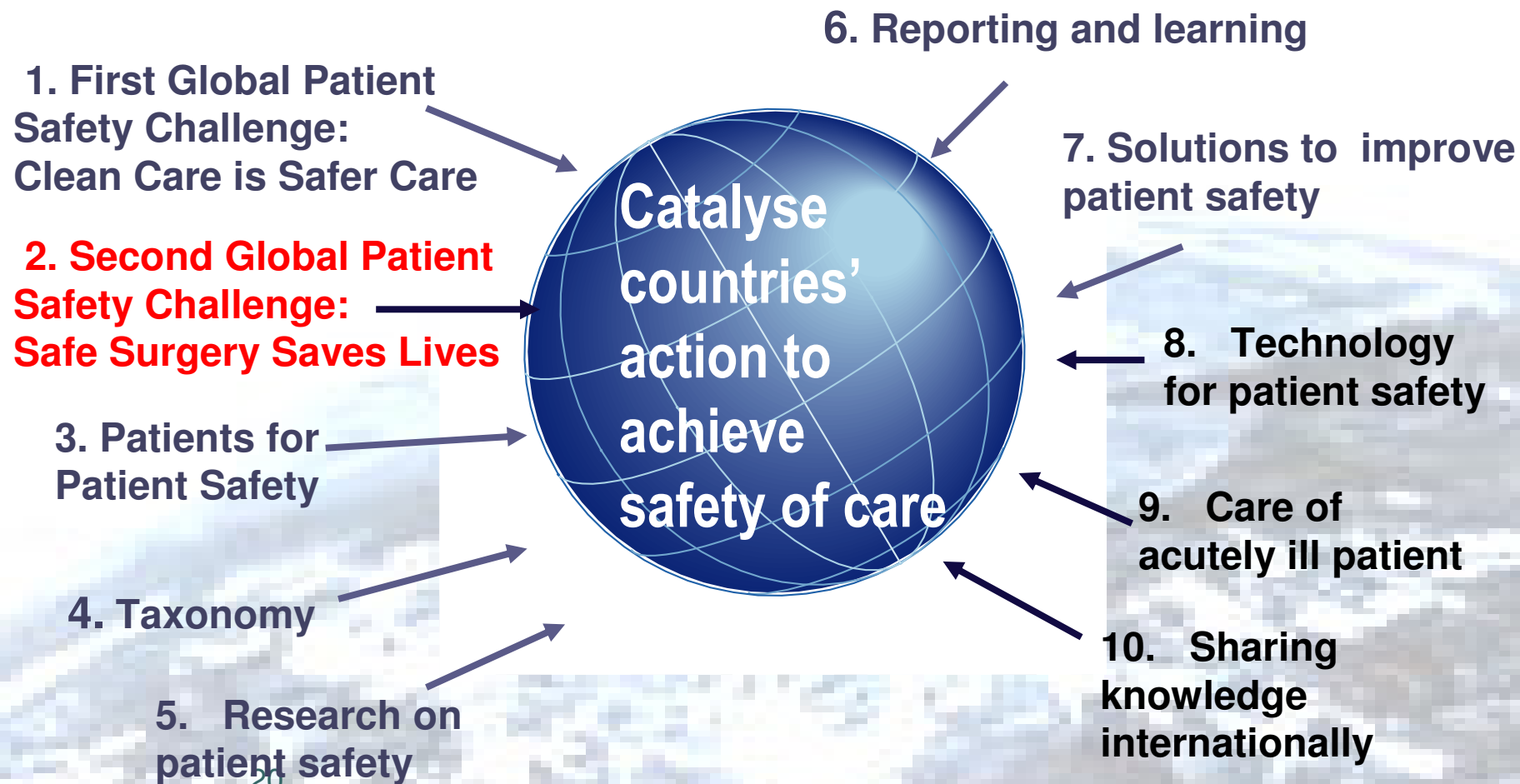   (http://www.who.int/patientsafety/taxonomy/icps_form/en/index.html)

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- **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/)

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Ten action areas 2007-onwards

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6. Reporting and learning

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

2. Second Global Patient Safety Challenge: Safe Surgery Saves Lives

3. Patients for Patient Safety

4. Taxonomy

5. Research on patient safety

Catalyse countries' action to achieve safety of care

7. Solutions to improve patient safety

8. Technology for patient safety

9. Care of acutely ill patient

10. Sharing knowledge internationally

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- **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)

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Countries committed to address HAI
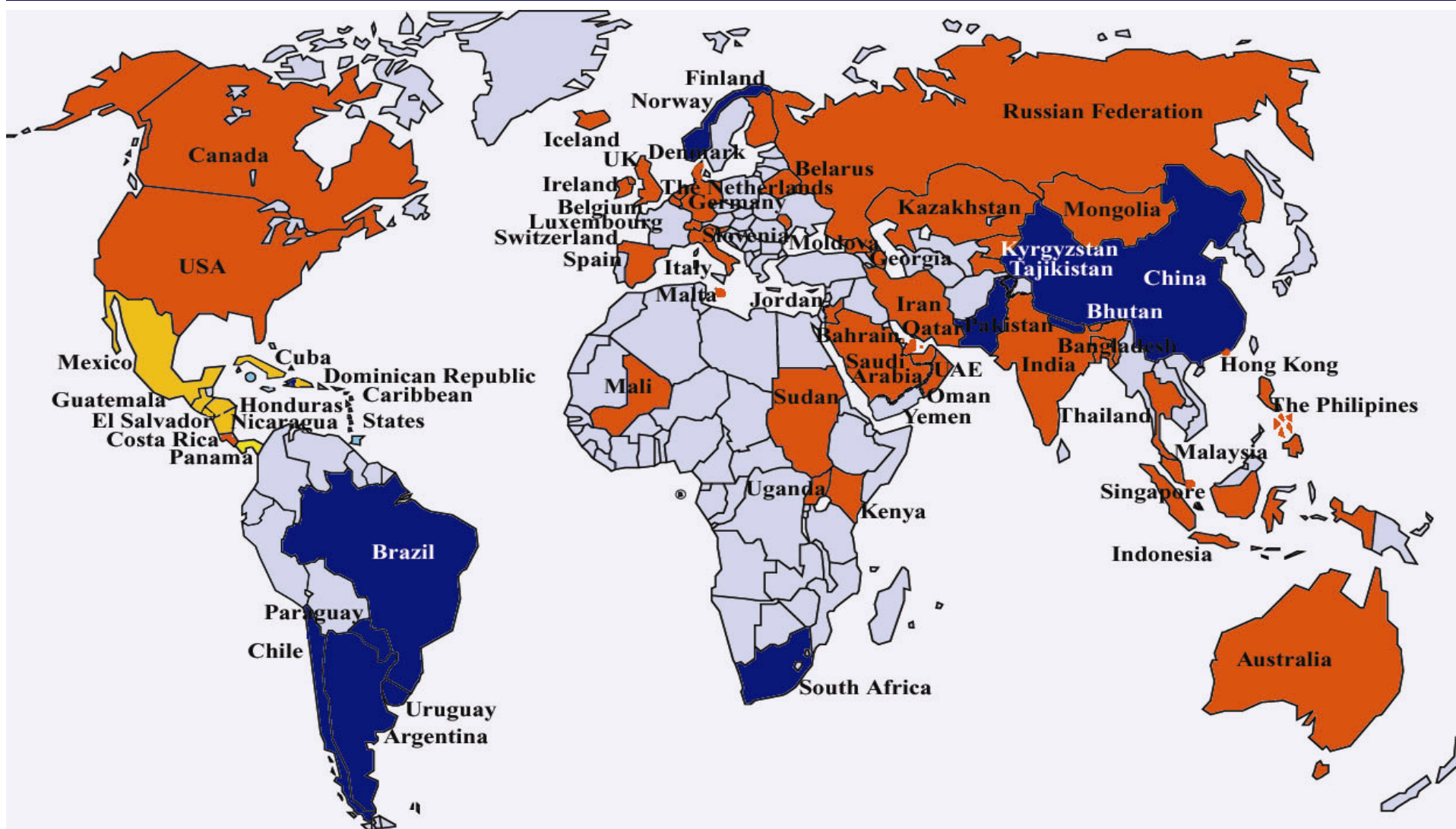
Patient Safety in Lebanon

o **Safety Culture among Lebanese Nurses assessed and appropriate training given**