A YEAR OF LIVING less DANGEROUSLY

WORLD ALLIANCE FOR PATIENT SAFETY

PROGRESS REPORT 2005
Every time I meet a patient or a family who has suffered because of a health care mistake, I know we are not working fast enough to make the far-reaching changes needed to improve patient safety. We need to act quickly; we need to set clear measurable goals; and we need to be accountable to patients everywhere for their delivery.
Sometimes prisoners who have been sentenced to death are known as “dead men walking”. This is because of the inevitability of the eventual outcome they face.

Time and time again, investigation of patient deaths as a result of health-care errors - and the stories of their families - show people whose fate seemed to have been determined from the moment they entered the health facility for care. They could almost have been described as “dead patients walking”. Their deaths resulted from a chain of system failures in which repeated opportunities to stop the inevitable outcome were missed, with tragic consequences.

Challenging the very idea that these patient deaths from unsafe care are inevitable, is a powerful element of the drive behind the World Alliance for Patient Safety.

A year ago, the World Alliance for Patient Safety was launched by the Director-General of the World Health Organization, Dr LEE Jong-wook, in Washington, DC. We have spent that year striving to put patient safety on the health care agenda of Member States and experiencing an unprecedented level of support from countries, experts, and patients from all corners of the globe.

We have been consistently impressed with the genuine commitment that the Alliance has enjoyed. In the past year alone, we have had patient safety meetings in five of the six WHO regions and the Alliance can claim to have involvement with over 140 Member States and experiencing an unprecedented level of support from countries, experts, and patients from all corners of the globe.

We continue to be struck by the similarity in the patient safety challenges faced by Member States, and there are of course differences in context. However, as we meet policy makers, clinicians, leaders and patients around the world, four core questions recur:

- How do we support patients, their families, and our health care staff when things go wrong?
- How do we learn from our mistakes and prevent other patients from being harmed by the same errors?
- How do we prevent the same problems recurring?

- How do we make safer health care possible in all health care environments from the most advanced tertiary hospital to the primary care clinic in a remote area of the world?

The reality is that substantial challenges remain. Despite the comprehensive work programme of the Alliance and the growing commitment to action on patient safety that we have witnessed, much remains to be done. The same errors and system failures are repeated again and again. Action to reduce known risks is often too slow. Most adverse event reporting systems are in their infancy. Many events are not reported by health-care workers. Understanding the causes and determinants of safety problems is limited, particularly in developing countries. Although there are examples of successful safety policy and programme initiatives, few have been expanded to the level of an entire health care system, let alone spread between countries worldwide. We are, so far, unable to measure our real progress internationally.

In my own presentations around the world during 2005, I have often highlighted the similarities between aviation and health care. I was particularly struck when the International Air Transport Association (IATA) announced that 2004 had been the international airline industry’s safest year ever. Airline accidents and fatalities, do sadly occur. Nevertheless, air travel has an impressive safety record. This has not happened overnight. It has been achieved through a systematic and thorough focus on safety over many decades. Despite the fact that some 1.8 billion people fly every year, airline fatalities worldwide, in 2004, were at the same level as in 1945, when only nine million people traveled by air. And the industry has set out programmes in place which it is confident will lead to a further 25% reduction in airline accidents between 2004 and 2006.

There are important differences between aviation and health care. However, at its core, the success of the aviation industry stems from a recognition that it is a high-risk industry and that systematic and sustained effort is needed to minimise all possible risks to passengers and staff.

It has taken health care too long to recognise that it is also a high-risk industry and the risks of patient care can be reduced by sustained effort over many years — just as the airline industry has done. Safe care cannot be optional for any health care system. It is the right of every patient who entrusts their care to us and the responsibility of those who lead and provide health care.

I am determined that before too long, the World Alliance will be able to announce the safest year ever for health care worldwide and that it will be able to show further improvements year on year. We must expect and work for nothing less. With this focus in mind, this report sets out the key achievements of the Alliance in its first year. In January 2006, we will publish our Forward Programme for 2006.

Sir Liam Donaldson
Chair
World Alliance for Patient Safety
Each time a patient is harmed by the health system, it is a betrayal of trust. These so-called “adverse events” are actually “reverse events”. Instead of advancing people’s health and well-being, medical errors send them backwards, causing more harm than good.

From every point of view the highest attainable standard of patient safety is desirable and necessary. The World Health Organization set up the World Alliance for Patient Safety in October 2004 to support the efforts of its 192 Member States to take up this challenge. Activities are going on locally, nationally and regionally. Networks of patients are promoting partnerships between consumers and health care providers. Information on the types of harm experienced by patients is being better analysed and understood. An internationally agreed research agenda on the problems faced is under development, and information sharing on problem-solving in different parts of the world structured into “solutions for patient safety”.

The Alliance has made a good start on tackling preventable harm through a range of strategies, including a series of two-year patient safety challenges, which address significant risks to patients. The first patient safety challenge is to make clean care, safer care. Health-care associated infection continues to affect hundreds of millions of people worldwide.

Simple actions, such as hand hygiene, can transform the level of risk in a health care environment. Opportunistic infections are a particular hazard for those living with HIV. Obstetric, neonatal and child care is still too often associated with unnecessary dangers to both mother and child. Bloodborne, foodborne, waterborne and airborne diseases can be rapidly and easily transmitted, especially in unhygienic surroundings.

Where health systems are under stress, for example in situations of natural disasters, crises, or simply in situations where resources are inadequate to the demands being made, it is essential to have well-established standards of cleanliness and care.

For the past year, the Alliance has been delivering a demanding agenda to ensure that patients’ right to safer and equitable care is met. I welcome its efforts to increase international collaboration in this field, support the agreed research agenda, and to promote existing patient safety interventions. The progress made is an encouraging illustration of how care can be made safer around the world.

Dr LEE Jong-wook
Director-General
World Health Organization
WOULD YOU EVER BOARD A PLANE IF YOU KNEW THAT HALF OF ITS EQUIPMENT WAS NOT WORKING?

IN DEVELOPING COUNTRIES, IT IS REPORTED THAT OVER 50% OF MEDICAL EQUIPMENT IN USE IS FAULTY. FAULTY EQUIPMENT KILLS PATIENTS.

At any given time 1.4 million people worldwide are suffering from an infection acquired in a health facility.

At the heart of a movement

Despite growing interest in patient safety, there remains a significant lack of progress in tackling adverse events in health care. A patient safety problem of global proportions continues to threaten hard-won gains in health. Adverse events can and do happen at an alarming rate. Studies have shown that in many developed countries one out of every 10 hospital patients experiences an adverse event that can lead to serious injury and death.

The situation in the developing world is even more serious than this with millions of patients enduring prolonged ill-health, disability and death caused by unreliable practices, services, and poor health care environments.

In October 2004, the World Health Organization with unanimous support from Member States agreed that the world’s response needed a vital boost of energy and innovation, partnerships, and substantial technical and financial resources.

As a result, the World Alliance for Patient Safety was established to be at the heart of a global movement striving for safe health care. In the past year, the Alliance intensified efforts to realize its mission through:

- patient empowerment
- facilitating research
- exploring the advantages of reporting
- ensuring that solutions can be fast-tracked
- developing evidence-based guidelines and interventions
- forging partnerships with technical and international agencies
- raising global awareness.
THE ALLIANCE HAS A FIRM OBJECTIVE TO DELIVER SIX PROGRAMMES WITHIN THE PERIOD 2005-2006:

Global Patient Safety Challenge: The topic for the period 2005-2006 is health care-associated infection. The Alliance will promote WHO strategies in the areas of hand hygiene, blood safety, injection safety, safe clinical practices, and safe water and sanitation in health care to help reduce the incidence of health care-associated infection.

Patients for Patient Safety: involving patient organizations and individuals in the work of the Alliance.

Developing an international taxonomy: ensuring consistency in the concepts, principles, norms and terminology used in patient safety work.

Promoting and coordinating research: developing a rapid assessment tool for use in developing countries, and undertaking prevalence studies of adverse events in a number of countries.

Solutions for patient safety: promoting existing interventions and coordinating international efforts to develop and disseminate solutions to reduce the risks of health care and improve its safety.

Reporting and learning: generating best practice guidelines for existing and new reporting systems, and facilitating early learning from the information available.

This report charts the progress achieved by the Alliance in 2005 in defining viable strategies to start reducing adverse events in health care and their terrible consequences.

**THE ORANGE WIRE TEST**

Imagine that an aircraft engine contained an orange-coloured wire essential to its safe functioning. Imagine that an airline engineer doing a pre-flight inspection spotted that the wire was frayed in a way that suggested a systematic fault rather than routine wear and tear. Imagine what would happen next. It is likely that most similar engines in the world would be inspected—probably within days—and the orange wire, if faulty, renewed. Like airlines, hospitals take charge of people’s lives many times a day. Yet, health care has lagged behind other industries in putting safety first in dealing with its consumers. A systematic fault that put patients’ lives at risk discovered in one country would not surely be rapidly and simultaneously corrected by health services across other countries throughout the world.

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

Died:
January 2001

Age:
18 months

Place:
Baltimore, MD, USA

Cause of Death:
Severe dehydration and administration of an un-prescribed pain-killing drug during a hospital admission.
The first Global Patient Safety Challenge for 2005-2006 is titled “Clean Care is Safer Care” and focuses on health care-associated infection. Health care-associated infection affects hundreds of millions of people worldwide and complicates the delivery of patient care. These lead to patient disability and deaths and generate significant, additional health-care expenditure.

The vision of the Global Challenge is simple: to catalyse worldwide commitment by policy-makers, experts, clinicians and patients to make “Clean Care is Safer Care” an everyday reality wherever health care is provided.

Professor Didier Pittet, Director, Infection Control Programme, Geneva’s University Hospitals, has been an inspirational leader for the development of the Global Patient Safety Challenge.

WHO and its’ partners launched the Global Patient Safety Challenge with the theme “Clean Care is Safer Care” on Thursday, 13 October 2005. As part of the launch, the WHO Guidelines on Hand Hygiene in Health Care (Advanced Draft) were made available. The morning session of the launch took place at WHO Headquarters in Geneva and the afternoon session at Geneva’s University Hospitals. Sir Liam Donaldson, chaired the launch.

The WHO-hosted launch staged a parade by children from the International School of Geneva who presented the problems of health care-associated infections on banners along with the WHO responses to tackle these infections.

During the event, WHO Headquarters in Geneva connected via video-link to several sites in the African, South-East Asian, European, Eastern Mediterranean and Western Pacific Regions of WHO. During the afternoon session at Geneva’s University Hospitals, the event connected via video-links to sites in Turkey, North America, including sites of major associations of health-care professionals. Several international societies and agencies such as the Society for Healthcare Epidemiology of America, Association of Professionals in Infection Control, the Centers for Disease Control and Prevention, Atlanta, the International Federation of Infection Control and many others participated in the afternoon session of the launch through videolink.

(http://www.who.int/patientsafety/events/05/global_challenge/en/index.html)
Key elements of the implementation of the Global Patient Safety Challenge which are being progressively implemented include:

- global and national “Clean Care is Safer Care” campaigns;
- an invitation to ministers of health from all WHO Member States to make a formal statement pledging to tackle health care-associated infection within their country;
- district testing of the new hand hygiene guidelines, along with selected actions from the other WHO strategies. This will occur within each of the six WHO regions. These pilot sites will provide local data on the resources required to carry out recommended actions and generate information on the feasibility, validity, reliability, and cost-effectiveness of interventions.

Country Statements pledging support to address health care-associated infection

An important part of the Global Patient Safety Challenge will be the opportunity for WHO Member States to make a formal statement pledging their support. Statements, drafted by individual countries, are likely to cover some of the following areas:

- Acknowledging the importance of health care-associated infection;
- Developing or enhancing ongoing campaigns at national or subnational levels to promote and improve hand hygiene among health-care providers;
- Making reliable information available on health care-associated infection at community and district levels to foster appropriate actions;
- Sharing experiences and, where appropriate, available surveillance data, with the WHO World Alliance for Patient Safety;
- Considering the use of WHO strategies and guidelines to tackle health care-associated infection, in particular in the areas of hand hygiene, blood safety, injection and immunization safety, clinical procedures safety and water, sanitation and waste management safety.
A key action within the Global Challenge is to promote hand hygiene in health care. Poor hand hygiene among health-care providers is a worldwide problem. Better hand hygiene has the potential to reduce infections in advanced health-care systems, as well as, at local dispensaries in developing countries.

In order to provide health care workers, hospital administrators and health authorities with the best scientific evidence and recommendations to improve practices, WHO developed new Guidelines on Hand Hygiene in Health Care (Advanced Draft). The development of the guidelines has brought together the expertise of over 200 leading specialists in infection prevention and patient safety.

During 2004-2005, two major consultation meetings were held and brought together over 60 international experts from around the world, for each consultation. Specific technical issues were addressed in more detail during several meetings of core groups of experts along with a number of taskforces. These include issues such as strategies to promote greater patient involvement; global implementation of a WHO hand hygiene formulation; indications for glove use and re-use, and; religious, cultural and behavioural aspects of hand hygiene, and campaigning.

Earlier in the year, on the occasion of the Fifty-eighth World Health Assembly in May 2005, an informal briefing took place at the Palais des Nations, Geneva on the 19 May 2005. The purpose was to inform country delegations about the Global Patient Safety Challenge and the development of the WHO Guidelines on Hand Hygiene in Health Care.
Some infection risks are of particular importance in specific parts of the world. The Global Patient Safety Challenge is collaborating with four WHO departments to develop an integrated package of strategies to address health care-associated infection.

These are:

- **Department of Blood Transfusion Safety**, to promote optimal use of hand hygiene associated with procedures for collection, processing and use of blood products.

- **Department of Vaccine Assessment and Monitoring and Immunization & Biologicals**, to promote optimal hygiene practices at the time of injection and immunization, including use auto-disposable syringes; and to ensure the safe disposal of sharps.

- **Department of Water, Sanitation and Health**, to develop a package of actions to ensure access and water quality to support hygiene and hand hygiene, and to ensure the sound management of waste.

- **Department of Clinical Procedures**, to develop education programmes promoting safety in surgical procedures tailored to the needs of health-care facilities.
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PATIENTS AND CONSUMERS OF HEALTH CARE ARE AT THE VERY CENTRE OF THE QUEST TO IMPROVE THE SAFETY OF PATIENT CARE. WHEN THINGS GO WRONG, THEY AND THEIR FAMILIES SUFFER FROM ANY HARM CAUSED.

Patients for Patient Safety, one of the six action areas of the Alliance, is designed to ensure that the perspective of patients and families, consumers and citizens is central to our work to improve the safety of health care. The Alliance is developing an international network of patients and patient organizations working to improve patient safety through active patient involvement and ensure patient participation in all of our own work programmes.

It is vital that this action area is patient-led. Ms Susan Sheridan, President of Consumers Advancing Patient Safety in the USA - who has experienced the tragic consequences of medical error in her own family - is leading this programme. Susan is supported by a small, informal steering group which has met regularly during the past year.

A world first, international 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 establishes them as committed patient safety champions. Workshop participants were drawn from 20 different countries and were selected following a worldwide, public call for expressions of interest. This reached over 2000 organisations and has generated a large group of interested stakeholders from all over the world.

As a global group, ‘Patients for Patient Safety’ champions will contribute to our ongoing work to promote partnerships between patients and health care providers and greater patient involvement in patient safety efforts throughout the world. As a result of the workshop, Patients for Patient Safety has established a statement of purpose and action plans have been developed for action in all WHO regions during 2006.

Patients and consumers have a tremendous opportunity to contribute to a safer health care system by playing a central role as partner in reporting, research, solutions, and safety in general. The Alliance programme “Patients for Patient Safety” embraces the belief that the patient/consumer perspective is pivotal in ensuring a health care system that is safe, compassionate and just.

Susan Sheridan, LEADER, PATIENTS FOR PATIENT SAFETY
The workshop was held 27 - 30 November in London, UK, in conjunction with the EU Summit on Patient Safety which the UK was hosting as part of their presidency of the EU.

The workshop, which was just the start of the Patients for Patient Safety work, brought together patients and consumers interested in working, in partnership with the World Alliance for Patient Safety as specially designated champions for advancing patient safety. Over time, these champions will act as advocates on behalf of patient safety and the work of the Alliance in their own countries and regions.

“Bridging the gap between the people on the patient led advisory council and the organization administering health care in the region is at once a rewarding and emotionally challenging experience; there are so many stories of loss”.

**Ryan Sidorchuk, Canada**

Daughter Paige died following an incorrectly diagnosed tumour

“Poor communication, an absence of procedures or their implementation resulted in equipment not being assembled in readiness to assist my son at birth and no intervention was provided to assist me or my son during the last 12 hours of labour and the birth process. My son died while he was being born.”

**Stephanie Newell, Australia**

“…taking into consideration the fact that during the period of my grandmother’s illness, doctors made three incorrect diagnoses, it wasn’t clear what was going on with her for about half a year. That caused prescription of the medicines which were completely irrelevant in my grandmother’s case which they caused a lot of side effects which basically resulted my grandmother’s inability to walk.”

**Vasyl Kvariuk, All-Ukranian Council for Patients’ Rights and Security**

“Further study is required in the area of Patient Safety and results disseminated, published and the flow of ideas shared. This subject requires soliciting for funding”.

**Cosmas Chola Kalwambo, Zambia**

Daughter died in hospital when her oxygen supply line ran out of oxygen and no warning was sounded.

“A lot has been achieved but there is still a lot to be done. This change is an ongoing process and it shall continue.”

**Deodatta Gore, India**
Commonwealth Fund’s 2005 Survey of Sicker Adults
ARE PATIENTS CANARIES IN A COAL MINE?

In 2005 the Commonwealth Fund undertook a survey, entitled Taking the Pulse of Health Care Systems: Experiences of Patients with Health Problems in Six Countries, which sought the views of sicker adults in: Australia, Canada, Germany, New Zealand, the United Kingdom of Great Britain and Northern Ireland, and the United States of America. One of the key areas of focus for the survey was medical error rates.

Taking the Pulse of Health Care Systems found that between a fifth (in the UK) and a third (in the USA) of adults questioned reported that they believe at least one of the following had occurred during their care:

- They experienced a medical mistake in treatment;
- There were given the wrong medication or dose;
- They were given incorrect results of a test;
- They experienced delays in being notified about abnormal test results.

Of all patient groups, the most vulnerable category was found to be patients in the USA who had seen four or more physicians in the last two years (48% of such patients reported an error in their care).

One of the most notable findings of the survey was that a majority of reported errors (60% or more across all six countries) occurred outside of hospital. Particular shortfalls in hospital discharge procedures and in the transition of patients between providers were highlighted. This indicates a need for health care organizations to shift their patient safety focus from exclusively a hospital setting and to instead encompass all health care settings. As the survey remarks: “These patients are the ‘canary in the coal mine’ of any health system”.

Extract from Taking The Pulse Of Health Care Systems: Experiences Of Patients With Health Problems In Six Countries by Cathy Schoen, Robin Osborn, Phuong Trang Huynh, Michelle Doty, Kinga Zapert, Jordan Peugh, Karen Davis, Health Affairs, November 4 2005

People’s Health Movement

The People’s Health Movement is an international movement bringing together several hundred non-governmental organizations around a campaign for the “Right to Health”.

Our central theme is that this fundamental right starts with primary health care and protection for the poorest populations. The World Alliance for Patient Safety “Challenge” themes for 2005-6 of safe potable water, sanitation, safe injection (eight billion out of 16 billion are still unsafe), safe blood, would mean better socio-economic conditions, a prerequisite to guarantee the health of the poorest. The Disability and Economics circle of the PHM is involved in advocacy for the 600 million people with disability, whose interests are forgotten. As systematically the poorest strata in any society, as users of health services, we, the disabled, have an overwhelming interest in making sure that health systems are safe which, in our view, demands that we link up with health services workers in international advocacy for adequate human resources. I like to remind people that a man who had had polio, who was in a wheelchair, saved America from the great depression and the world from Nazism, F.D.R, Roosevelt, with a State emphasis on the development of public social programs where the free Darwinian market left to itself had totally failed.

Garance Upham,
CHAIR, DISABILITY AND ECONOMICS CIRCLE, PHM GENERAL SECRETARY SAFE OBSERVER INTERNATIONAL
Betsy Lehman

Died: December 1994
Age: 39 years old
Place: Boston, USA
Cause of death: Administered with four times the prescribed dose of a chemotherapy drug, resulting in heart failure.
Improving patient safety requires better information sharing about the number, types, causes and consequences of errors and adverse events. The lack of a standardized nomenclature and patient safety classification significantly hinders this effort. It makes intra- and inter-country comparison complex, cumbersome and inaccurate.

A literature review of current approaches to classifying patient safety information was undertaken in 2003 and updated in 2005. These reviews suggest that:

- there is no agreed classification system for patient safety data;
- multiple approaches have been developed serving different purposes;
- there is considerable variation in the approaches being used and little integration;
- the environment is rapidly changing with developments in patient safety and health.

**Aim:** 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, in an adaptable yet consistent way, across the entire spectrum of health care and across cultures and languages.

**Taxonomy Drafting Group, October 2005**
By way of example, the table below illustrates the multiplicity of some of the terms and definitions for medication safety informatics.

### Medication safety related terms and definitions

- **Adverse event** - 21 definitions
- **Error** - 13 definitions
- **Adverse drug reaction** - 11 definitions
- **Adverse drug event** - 10 definitions
- **Incident** - 8 definitions
- **Near miss** - 8 definitions

Results of a web search of terms and definitions of 160 organisations involved in medication safety published in Yu KH, Nation RL and Dooley MJ. Multiplicity of medication safety terms, definitions and functional meanings: when is enough enough? in *Quality and Safety of Health Care* 2005; 14: 358-363

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**THE WAY FORWARD**

*Taxonomy for Patient Safety* aims to build international consensus on a high level taxonomy and classification system that will help to support data analysis and aggregation within and across countries. The World Alliance for Patient Safety wants to ensure that information about harm to patients is analysed, understood and relevant in countries and across the world, to help make health care safer.

It is not intended to replace existing taxonomies but rather to provide a framework in which diverse approaches can be aligned. This will enable the global health-care community to review, evaluate and learn from near-miss and adverse event data at the international level, as well as enable countries to benchmark and monitor individual progress towards improving the safety of health care against international norms.

The Alliance will ensure that future work links with developments around key international classifications, especially with those belonging to the WHO Family of International Classifications and the WHO Drug Dictionary.

Close links have been established with the WHO Department of Measurement and Health Information Systems (MHI). Dr Jerod Loeb, Mr Andrew Chang and Dr Heather Sherman from the US Joint Commission on Accreditation of Healthcare Organizations are also providing technical support to WHO for this work.
Patient Safety......
many languages, one focus

Developing an international taxonomy - First Drafting Group Meeting, Vancouver Canada

In October 2005, the first meeting of an expert drafting group was convened comprising leading experts in patient safety, information management and health classification. The purpose of an international taxonomy and links to broader classification developments were discussed. The scope of work involved in adapting the Patient Safety Event Taxonomy (PSET) for possible use as an international framework was also reviewed. The PSET, developed by the US Joint Commission on Accreditation of Healthcare Organizations, has been officially endorsed by the National Quality Forum in the USA.

There was general interest in building on the work of the PSET as well as other taxonomies in use to ensure that the final product meets a unique set of international needs. Work to be taken forward work over the next eighteen months will include:

1. defining the scope and developing a list of key concepts;
2. testing these concepts with WHO Member States and other stakeholders;
3. developing a conceptual infrastructure for the taxonomy that is both consistent and comprehensive;
4. undertaking a two step field test process (α and β testing).

It is expected that the draft taxonomy will be available for field testing by early 2007.
Kevin Murphy

Died: September 1999

Age: 21 years old

Place: Cork, Ireland

Cause of death:
Died because of failure to detect an excessively high blood calcium level.
Knowledge is the Enemy of Unsafe Care

The Alliance action area Research for Patient Safety is working to develop an internationally agreed research agenda for patient safety. The Alliance is also commissioning research in specific areas in which there are knowledge gaps and where there is particular value in carrying out international work.

The problem is massive

Since the 1990s, a powerful body of research evidence from record review studies has been accumulated worldwide, looking at the number and nature of adverse events in different countries. One of the limitations of the current data is that research primarily drawn from the experience of developed countries. At present, there are few comparable studies from developing countries and those in economic transition. However, indications are that the problem of patient safety is just as much an issue, if not an even greater one, in those countries, although the potential sources of harm may be very different.

The Alliance aims to work with a cross-section of developing and transitional countries to develop better understanding of the patient safety challenges they face and to develop appropriate measurement methodologies and tools. To initiate this work, in November 2004, the Alliance brought together representatives of twelve countries (two from each WHO region) in a two day meeting to explore their interest in taking part in this project. As a result, most participants showed significant interest in being part of an active research network to share and learn methods to explore the problem and nature of patient safety in their countries. It was agreed that WHO would facilitate the training and technical support needed to initiate small prevalence studies in interested countries.

During 2005, an expert group including Dr Ross Wilson, Dr Philippe Michel, Professor Charles Vincent and various WHO staff members has met three times to develop the research proposal. The project will involve up to twelve countries and will review the size and nature of patient harm in a sample of health-care services. This project will be underway in early 2006. Countries expressing interest include Poland, Estonia, Egypt, Tunisia, Benin, Kenya, South Africa, Costa Rica, Peru, Thailand, Malaysia, Myanmar, and the Republic of China.
ACTING NOW

The Alliance is supporting research in specific clinical areas which address significant risks to the safety of patient care. A planned research study will focus on identifying the principal patient safety causes of maternal death, and other serious adverse events occurring during delivery, in selected Sub-Saharan countries. The research will take place in Tanzania, Uganda, South Africa and possibly Ethiopia. The Making Pregnancy Safer and the Reproductive Health and Research Departments at WHO will also collaborate in the initiative.

The WHO Department of HIV/AIDS has granted a small amount of funds to conduct at least two research studies that focus on adverse events related to the care of HIV Patients. The Alliance is working with Prof. Stuart Whittaker of the Council for Health Service Accreditation of South Africa (COHSASA) on a study to be conducted in one of the poorest provinces of South Africa. The study will focus on the occurrence of selected adverse events, including needle stick injuries, poor adherence to ARVs, lactic acidosis, and the poor management of opportunistic infections.

Peru:
IMPROVING PATIENT SAFETY

Sometimes, small actions yield outcomes greater than initially foreseen. The participation in the first research workshop held in Amsterdam 2004, of Peruvian delegates Drs. Polo and Llanos, and afterwards, with the support of Dr Chaw from the Ministry of Health, and of the PAHO/AMRO country office, helped improve the profile of patient safety in Peru. Few months after the workshop took place, a national strategy for patient safety is taking shape. Some of the elements of the Joint PAHO/AMRO - Peruvian Ministry of Health National Programme for Patient Safety are:

1. Basic voluntary hospital reporting system;
2. Setting-up a national patient safety technical unit at the Ministry of Health;
3. Selection of adverse events for monitoring and surveillance;
4. Analysis of the legislative framework;
5. Awareness raising strategy;
6. Design of a National Patient Safety Alliance, involving major local stakeholders.

The Ministry of Health has initiated training programmes on patient safety, and issued a risk-assessment and monitoring project as part of the hospital audit process.
On 1 November 2005, the Alliance hosted a meeting in conjunction with the Agency for Healthcare Research and Quality in the USA, to consult on the development of an international patient safety research agenda. For the first time ever, researchers on safety in non-health-related industries, patient safety, and health services researchers, together with specialists on patient safety, senior policy-makers, representatives from international organizations, research funding organizations and WHO officials came together to discuss international research needs. The meeting discussed top global priorities for research on patient safety and mechanisms for ongoing dialogue and continuous review of agreed priorities.

Costa Rica: PATIENT SAFETY

The National Programme for Patient Safety of the Costa Rica Social Security Fund was launched in February 2005. The programme aims to improve the effectiveness of health care within the region using the best available scientific evidence. The programme objectives are: the identification of errors; the reduction of patient harm associated to medical errors; the learning through errors; and the prevention of patient harm.

For the past decade, Costa Rica has developed a National Programme for Continuous Quality Improvement. The PAHO/AMRO country office has been a close partner of the Ministry of Health in all national efforts to improve the care of Costa Rican citizens. In November 2005, the National Quality Forum focused on Patient Safety.

RESEARCH MEETING BY THE WORLD ALLIANCE FOR PATIENT SAFETY AND AGENCY FOR HEALTHCARE RESEARCH AND QUALITY

Cross-section of topics discussed at the meeting to develop an international patient safety research agenda:

- Challenges in measuring outcomes;
- Need for appropriate metrics, particularly in those areas of health care where research is less developed such as primary care, mental health care, rehabilitation;
- Need for innovative methods to evaluate safety interventions and solutions;
- What methods can be drawn from other industries?
- How to best involve the consumer in research on patient safety;
- Need for economic analysis of patient safety, incentives and barriers;
- Methods on human behaviour and the psychology of organizations;
- Need to think outside traditional lines of support for research funding;
- Need to establishing alliances with other areas of research with better funding;
- Recognition of specific capacity needs in developing countries.
WAYNE JOWETT

Died: January 2001
Age: 18 years old
Place: Nottinghamshire, UK
Cause of death: A chemotherapy drug (vincristine) was administered into his spine instead of into a vein causing gradual paralysis and death.
“The Joint Commission for Accreditation of Healthcare Organizations and Joint Commission International are particularly pleased to be playing an active role in the World Alliance for Patient Safety. We are firmly committed to the Alliance’s objectives and view its creation as a major milestone in global efforts to make health care safer at every level in developing, transitional, and developed countries.

The collaborative underpinnings of the World Alliance provide a unique opportunity to gather, assimilate, and disseminate knowledge about patient safety interventions that are known to be effective in reducing risks for patients. Working with patient safety leadership organizations and experts around the world, we can optimize the deployment of precious resources in identifying or, if necessary, designing systems and other solutions that will help countries address their high risk patient safety problems.

During our first year as a Collaborating Center for Patient Safety Solutions, we intend to create an international network that will permit us to systematically identify, evaluate, and disseminate patient safety solutions; to develop an in-depth understanding of potential barriers to the adoption of patient safety solutions in various countries or world regions; to begin to devise strategies to facilitate adaptation of patient safety solutions where unique cultural or health-care delivery characteristics exist; and to distribute at least six solutions through a web-based solutions library. Through the World Alliance, we hope to help make health care around the world a process which “first does no harm.”
The most important knowledge in the field of patient safety is understanding how to prevent harm to patients. A first step to turning such a vision into reality is to scale up interventions and actions that have solved patient safety problems in one part of the world and make them widely available in a form that is accessible and understandable. Solutions for Patient Safety is working to increase international collaboration on promoting existing patient safety interventions and improve coordination of international efforts to develop future solutions.

SAFETY SOLUTIONS FROM AROUND THE WORLD

Safety solutions are interventions and actions which prevent the recurrence of patient safety problems and reduce risks to patients. Examples of specific safety solutions include:

Incorrect administration of vincristine (via intrathecal injection rather than intravenous)

The Joint Commission on Accreditation of Healthcare Organizations has produced a four-point checklist to follow when injecting drugs intrathecally, to ensure the right drug is injected in the right place.

Incorrect placement of nasogastric feeding tubes

- The National Patient Safety Agency in England and Wales is collaborating with the UK Medicines and Healthcare Products Regulatory Agency as well as industry to identify possible improvement to feeding tube design.

Wrong site surgery

- The Joint Commission on Accreditation of Healthcare Organizations has produced a “Universal Protocol” which outlines steps for ensuring right patient, right procedure, right site.
- This has been adapted for use by the Australian Council for Safety and Quality in Health Care as well as the Danish Patient Safety Society.

Administration errors of Potassium Chloride

- The Canadian Patient Safety Institute, the Joint Commission on Accreditation of Healthcare Organizations, National Patient Safety Agency and the Australian Council for Safety and Quality in Health Care all recommend removing Potassium Chloride concentrate from wards, and only allowing pre-prepared doses onto wards.

Missed diagnosis of neo-natal hyperbilirubinemia leading to childhood kernicterus

- The Joint Commission on Accreditation of Healthcare Organizations issued “Sentinel Event Alerts” highlighting key steps to reduce the risk of a newborn child developing severe hyperbilirubinemia, and recommended a bilirubin test for all neonates regardless of whether they appear to have jaundice or not.

To spearhead work on safety solutions, the Alliance has been delighted that the Joint Commission on Accreditation of Healthcare Organizations (JCAHO) and Joint Commission International (JCI) were designated as a WHO Collaborating Center on Patient Safety (Solutions).

KEY OBJECTIVES OF THE WHO COLLABORATING CENTER ON PATIENT SAFETY (SOLUTIONS):

- Identify and conduct research into solutions in areas of patient safety, in collaboration with international experts and agencies;
- Disseminate these solutions, adapt existing solutions for use around the world and provide support in their implementation;
- Promote and provide education on patient safety solutions to the international health-care community.
The Collaborating Centre was officially launched at the National Press Club in Washington, D.C. on 23 August 2005. A press conference was organized for the launch event during which speeches were made by Sir Liam Donaldson, Chair of the World Alliance for Patient Safety, Dr Dennis O’Leary, President of the Joint Commission and Ms Karen Timmons, CEO of JCI. Dr Mirta Roses, Regional Director of AMRO/PAHO spoke on behalf of the WHO Regional Office while Dr Carolyn Clancy, Director, Agency for Healthcare Research and Quality also gave words of support to the initiative.

Patient safety alerts **issued in Denmark and Spain**
PAT SHERIDAN
Died: 2002
Age: 45 years old
Place: USA
Cause of death:
Failure to communicate his diagnosis of spinal cancer to him or his family.
A few years earlier, Cal, Pat and Sue Sheridan's son, suffered kernicterus, a brain injury characterized by cerebral palsy and other associated neurological deficits, caused by the failure to treat neonatal jaundice.
Effectively learning when things have gone wrong is an essential part of improving patient safety. Understanding the causes of adverse events and errors helps to identify gaps, inadequacies and weaknesses in health-care systems. Such insights can help to prevent major accidents, but we will not be able to benefit from them unless clinicians feel “safe” in reporting adverse events and near misses.

Reporting systems are by no means a new phenomenon. They have been used as an error-prevention tool in many high risk industries for decades. These includes aviation, nuclear power, petrochemical processing, steel production and military operations. More recently, reporting and learning systems have gained impetus within health care. Initiatives are now underway in many Member States to collect, report and analyse data about patient safety problems.

To support these initiatives, the World Alliance action area Reporting and Learning aims to help countries establish and improve reporting and learning systems. The Alliance is also exploring ways of promoting more systematic learning across countries.

**DRAFT GUIDELINES ON ADVERSE EVENT REPORTING AND LEARNING SYSTEMS**

In November 2005, the Alliance launched draft WHO Draft Guidelines on Adverse Event Reporting and Learning Systems. These guidelines provide practical guidance to Member States on the key issues involved in designing and implementing effective patient safety reporting and learning systems. The guidelines have been developed by Professor Lucian Leape, with assistance from Dr Susan Abookire. They incorporate input from key international experts and the results of a country survey of reporting systems worldwide.

**SHARING LEARNING INTERNATIONALLY**

The belief that one day it may be possible for the bad experience suffered by a patient in one place to be the source of transmitted learning that benefits future patients in many other countries around the world is a powerful element of the vision behind the Alliance.

To help realise this vision, the Alliance has been working with the WHO Foundation Collaborating Centre for International Drug Monitoring and Patient Safety on a pilot project to collect and analyse information about adverse incidents related to drug prescribing, dispensing and administration. Safety issues related to the use of medicines are one of the leading causes of preventable harm to patients. Global reporting has the potential to increase international awareness of the causes of drug-related adverse incidents and inform preventive strategies.

The project will pilot an extended role between six to eight National Centres for pharmaco-vigilance. Interested centres are found in Morocco, Sri Lanka, Moldova, New Zealand, Nigeria, Brazil, Ghana and Italy. These centres will collect and analyse information on adverse incidents relating to drug prescribing, dispensing and administration. The project will commence in 2006.

The overarching challenge, ripe for transnational collaboration, is identifying the most effective strategies for translating information on errors and near misses into safety for patients.

**Dr Carolyn Clancy and Dr Daniel Stryer**
Centre for Quality Improvement and Patient Safety
US Agency for Healthcare Research and Quality
BMJ 330, March 2005
Evangelina Vásquez was pregnant with her first child in 1994. Uriel suffered permanent brain damage as a result of fetal distress and neonatal jaundice because:

- Chain of errors related with incorrect testing of her blood type
- Very long labour ending in caesarean section.
- Mother and baby discharged too quickly.

Perspectives in Health, the magazine of the Pan American Health Organization

Alan Brant was 54-years old when in December 2000, he was permanently disabled following the unnecessary removal of part of his oesophagus, incorrectly thought to be cancerous. The biopsy supposedly revealing cancerous oesophageal tissue and leading to the operation, had been contaminated in the lab by a tiny fragment of malignant tumour from a previous test.

Alice Kabusingye
Aged 50 years of Kyabwambe village in Uganda, Alice, had her fingers amputated after a malaria drug was injected into a vein in her arm rather than a muscle.

Ian Kelly
Surrey, UK
In the year 2000, 41-year old Ian Kelly contracted MRSA following a routine leg operation. Four years later Ian remained ill and agreed to a through-the-knee amputation.

A Lifelong Challenge

Uriel and his Mother

Evangelina Vásquez,
Mexico City, Mexico
Evangelina Vásquez was pregnant with her first child in 1994. Uriel suffered permanent brain damage as a result of fetal distress and neonatal jaundice because:

- Chain of errors related with incorrect testing of her blood type
- Very long labour ending in caesarean section.
- Mother and baby discharged too quickly.

Perspectives in Health, the magazine of the Pan American Health Organization
Reducing accidents and the risk of error in health care requires a significant and sustained response at global, regional and national levels. 2005 was a significant turning point in the world's response to patient safety with the launch of the World Alliance for Patient Safety in late 2004. The Alliance set an ambitious work programme for 2004-2005 calling for accelerated efforts to improve the safety of care.

The work of the World Alliance for Patient Safety runs through all levels of WHO. The Alliance Secretariat is based in the Evidence and Information for Policy Cluster, within WHO Headquarters as well as in Regional Offices. The Alliance coordinates the activities between country, regional and headquarters offices; these are critical for the effective development and implementation of plans, strategies, programmes and interventions.

The World Alliance for Patient Safety also depends on the commitment of its partners and technical experts from around the world and other WHO departments, who help extend the capacity of the Alliance Secretariat with operational and technical support.

Beyond enabling the core functions of the Alliance, partnerships complement its focus to help improve on a global level one of the basic goals of medical practice “First do no harm”.

This collaboration often involves the establishment and operation of programme-based working groups or task forces in order to advance efficiently the work in specific areas of common interest.

The Alliance has benefited from the consistent support of the International Hospital Federation, the International Council of Nurses, the International Pharmaceutical Federation, the International Federation of Red Cross and Red Crescent Societies and the World Medical Association.

Both developing and developed country non-governmental organizations and agencies participate in the Alliance. Some examples include People's Health Movement, Consumers Advancing Patients Safety, the International Federation for Medical and Biological Engineering and many others.
Recognising that patient safety is a pressing health care challenge worldwide, the International Council of Nurses welcomes the establishment of the Patient Safety Alliance, addressing the very critical issues of patient safety and adverse medical events - in and out of the hospital. It is essential that the health professions, and nursing in particular, be engaged and work hand in hand with the Alliance, with patients and with all actors in the health care arena on this important initiative. Nurses are at the front lines of patient care delivery - 24 hours a day seven days a week, in hospital, primary care, home and community settings. They often have contact with people at very difficult times, when patients are physically and psychologically vulnerable and they play an essential role in ensuring the delivery of safe care by the whole health team. Health care interventions are intended to benefit the public, but due to the complex combination of processes, technologies and human interactions there is an inevitable risk that adverse events will happen. Identifying and reducing the occurrence of these errors and improving the safety and quality of health care is a priority issue for nursing and health services.

WHAT SOME PARTNERS SAY:

International Council of Nurses

As the worldwide body for hospitals and healthcare organisations, the International Hospital Federation (IHF), founded in 1947 with membership in over 100 countries, is driven by its founding ethos that it is the right of every human being irrespective of geographical, economic, ethnic or social condition to enjoy the best standard in quantity and quality of health and access to hospital and health care services. This vision is promoted through the dissemination of evidence-based information, fostering of international partnerships that promote interaction among public and private hospitals and healthcare organisations, the community and commercial entities, the exchange of knowledge and experience on best practice in medical standards and patient care as well as the ethical behaviour and standards of integrity required to govern, lead and manage healthcare organizations.

The Global Alliance for Patient Safety initiative is most timely and apt, firstly, because in 2004, the IHF Governing Council revised its mission statement in order to specifically incorporate the theme of ‘patient safety’, in recognition of and response to the growing global drive to tackle patient safety issues. Secondly, it aligns with the objectives of the Federation’s water and sanitation project, initiated in 2003, aimed at assessing the impact of improved water quality, safe hygiene practices, developing strategies for the use of healthcare settings as focal points for community education around safe water, sanitation activities and hygiene practices and introducing improved safer practices and promoting best practices already in place.

The IHF, therefore, fully endorses and welcomes the opportunity to be involved as an official partner in this global endeavour, with whose vision and interests it fully identifies and through which it envisages much potential for collaboration.

Professor Per Gunnar Svensson
Director General
International Hospital Federation

“...an international phenomenon, and the Alliance is providing a truly international response. Through the efforts of the World Alliance for Patient Safety, we can envision a time when health care will be safe for all nations’ citizens.”

Dr Carolyn M. Clancy
DIRECTOR OF THE AGENCY FOR HEALTHCARE RESEARCH AND QUALITY
The International Alliance of Patients’ Organizations shares with the WHO initiative, Patients for Patient Safety, a commitment to bring the patient to the centre of healthcare. Patient safety issues affect patients around the world regardless of the status of their national healthcare system and the involvement of patients to improve the safety and quality of healthcare represents a rich knowledge and information resource. It is for these reasons that IAPO is pleased to work through Patients for Patient Safety in collaborative partnership with a wide range of stakeholders to encourage and enable patients to raise awareness of patient safety issues and connect with the health system in a coordinated, powerful and highly effective way.

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 healthcare 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 health care. Through the development and implementation of programs that encourage all pharmacy professionals to take an active role in the advocacy of patient safety, FIP aims to make a significant contribution to remedying this threat to the health and welfare of the global community.

A.J. Hoek
General Secretary and Chief Executive Officer
International Pharmaceutical Federation

International Federation of Red Cross and Red Crescent Societies

The International Federation of Red Cross and Red Crescent Societies supports the Global Alliance for Patients Safety. Patient Safety is an item of a great significance to many National Red Cross and Red Crescent Societies throughout the world, all of which serve as auxiliaries to Government and the public authorities, and being important members of civil society, are actively advocating for the most vulnerable through innovative partnerships.

Australian Council for Safety and Quality in Health Care

Improving patient safety is an important, national agenda in Australia. Working with all involved in health care, over the past five years, the Australian Council for Safety and Quality in Health Care has put in place a solid platform of reforms to help improve the safety and quality of health care. Strong links have been made to the work of the World Alliance for Patient Safety. This has allowed Australia to play an active role in the development of a global patient safety agenda, as well as help us to learn from the best of international experience.

Professor Bruce Barraclough, Chair,
AUSTRALIAN COUNCIL FOR SAFETY AND QUALITY IN HEALTH CARE 2000 -2005
IFMBE LINKS WITH THE WORLD ALLIANCE FOR PATIENT SAFETY TO IMPROVE PATIENT SAFETY

The International Federation for Medical and Biological Engineering (IFMBE) is an NGO closely cooperating with WHO in the areas of medical devices, policy and planning, quality and safety, norms and standards, technology management and capacity building.

IFMBE is fully supporting the World Alliance for Patient Safety through its participation in Alliance initiatives and events as well as through its own patient safety activities which include:

- the organization of patient safety symposia (www.biomedea.org),
- participation in the World Standards Cooperation (WSC) Healthcare Technology Task Force,
- promotion of biomedical and clinical engineering research related to patient safety,
- health technology assessment and management,
- educational activities including quality assurance measures with regard to patient safety.

Alliance Day

As part of its annual activities the World Alliance for Patient Safety is committed to holding an Alliance Day every year to report on progress achieved and discuss new areas of action for improving the safety of care. This annual event aims to build on political momentum and strengthen commitment of interested countries, health care agencies and many other partners on the critical role of patient safety.

Each year, the Alliance Day takes place in a different WHO region. In September 2004, the pre-launch Alliance Day took place in Shanghai, the People’s Republic of China.

Alliance Day 2005 was held in Moscow, Russian Federation on 9 December and was followed by a workshop on Saturday 10 December 2005 entitled “Institutionalization of Patient Safety: National and Hospital Perspective”. This year’s event brought together key policy makers, NGOs and civil society groups from the WHO European Region as well as experts from around the world to discuss patient safety. Technical progress made at regional level was highlighted with a particular focus on the Commonwealth of Independent States (CIS) and Baltic countries.

Regional Strategies

A vital part of global action on patient safety is to develop regional strategies for patient safety within each of the six WHO regions. Each Regional Office of WHO has a focal point for patient safety who leads this work in collaboration with the Alliance. Regional strategies aim to facilitate the establishment and strengthening of patient safety programmes within Member States through identifying:

- key regional priorities;
- areas for regional collaboration;
- ways in which regional action can contribute to the global work of the Alliance.
During 2005, regional patient safety meetings were held in three WHO regions. These meetings aimed to raise awareness of patient safety and the work of the Alliance, to galvanise commitment to action within regions and Member States and to help ensure that Alliance priorities and initiatives are relevant to regional and country needs.

The Eastern Mediterranean Region of WHO

In December 2004, the government of Kuwait hosted an inter-country consultation on patient safety with countries from the eastern Mediterranean region of the WHO. Following an intensive four-day meeting, priorities for country and regional action were identified in the form of a draft Kuwait Declaration for Patient Safety.

The African Region of WHO

In January 2005, the Alliance supported two meetings within Africa. The first meeting in Nairobi, Kenya drew together health service staff from across Kenya as well as Ministry representatives from other east African countries. The meeting was organised in conjunction with the Ministry of Health, Kenya and the WHO Representative in Kenya.

On this occasion, the Alliance heard about the enormous challenges facing health care in Africa. These included the HIV/AIDS epidemic, extreme poverty, inadequacy of health financing and a history of failed health reforms. A uniquely African model of patient safety was suggested encompassing political will, solidarity financing, human resources, evidence base, generic drugs, and empowerment of women.

A second meeting in Durban, South Africa, drew together a range of policy makers, senior clinicians, health care managers and technical experts from within South Africa as well as other African countries.

At this meeting the Alliance learnt about significant initiatives underway to improve patient safety in South Africa and the particular challenges in terms of workforce supply and retention, ensuring fair access to health care and the HIV/AIDS epidemic. A number of steps were identified for country level action on patient safety.

Ten Action Points

1. Raise awareness
2. Promote understanding of the underlying concepts
3. Showcase achievements
4. Gain commitment at the highest level and the front line
5. Establish technical programs and support
6. Provide high quality information
7. Demonstrate progress
8. Involve patients as partners
9. Embed in education and training
10. Work with the World Alliance for Patient Safety.

The European Region of WHO

A number of key agencies are working together to tackle patient safety in Europe. These include the European Commission, the Council for Europe and the Organisation for Economic Co-operation and Development. The Alliance has been working closely with the WHO Office for the European region to bring this work together into an overall patient safety strategy for the European region of WHO.
A consultative meeting of representatives from countries of the WHO region, along with the Alliance and these key agencies was held in November 2005 in London. At the consultative meeting the Alliance and European partners provided an overview of their work on patient safety. The results of a survey with Member States on national patient safety programmes undertaken by the WHO regional office were also discussed. A number of potential areas for regional collaboration were highlighted. A commitment was made to take forward work on a strategy for patient safety within the WHO region building on the work of the Alliance, key European partners and work underway within Member States.

This followed a highly successful international Summit on Patient Safety which was organised by the UK as part of the UK Presidency of the EU. The Summit highlighted world action on patient safety bringing together hundreds of international and European politicians, experts, patients, clinicians and many other stakeholders.

The Alliance is committed to supporting Member States to develop effective patient safety programmes

Professor Dianne Parker of the University of Manchester has been commissioned by the World Alliance for Patient Safety to develop a tool for the self-assessment of national patient safety cultures. The tool, which will be based on one developed for Royal Dutch Shell, to measure the perceived maturity of an organisation’s safety culture, will allow an assessment to be made of the relative maturity of countries in terms of patient safety culture.

The unique approach of MaPSaF is that:

- the content is derived solely from those with most experience of the field;
- it treats safety culture as a multidimensional concept;
- it indicates the developmental nature of safety culture, showing those with a less well developed safety culture what a more mature culture would be like.

It can be used:

- To raise awareness/prompt reflection and discussion of patient safety;
- To profile areas of relative strengths and weaknesses in national safety culture;
- To highlight differences in perceptions across professional groups;
- To help evaluate any specific intervention to change the safety culture.
Some patient safety activities around the world in 2005

Acronyms:

ACSQHC: Australian Council for Safety and Quality in Health Care
COHSASA: Council for Health Service Accreditation of South Africa
CPSI: Canadian Patient Safety Institute
DSFP: Dansk Selskab for Patientsikkerhed (Danish Society for Patient Safety)
FAD: Fundacio Avedis Donabedian
HMC of GCC: Health Ministers’ Council of the Gulf Co-operation Council states
IHI: Institute for Healthcare Improvement
JCAHO: Joint Commission for the Accreditation of Healthcare Organizations
NPSA: National Patient Safety Agency

Symbol indicates countries which have made statements since 14 October 2005, pledging support to the World Alliance for Patient Safety to tackle health care-associated infections. These countries are:

- Kingdom of Bahrain
- Hong Kong, People’s Republic of China
- United Kingdom of Great Britain and Northern Ireland
- Kingdom of Saudi Arabia
- Ireland
- Switzerland
- Republic of the Philippines
- Kingdom of the Netherlands
Building Global Momentum

World Alliance for Patient Safety Website Resources:
http://www.who.int/patientsafety/en/

- **6 Programmes of the Alliance:**
  - Global Patient Safety Challenge
  - Patients for patient safety
  - Taxonomy
  - Research for patient safety
  - Solutions to reduce the risks of health care and improve its safety
  - Reporting and learning for patient safety

- **Launch of the World Alliance for Patient Safety**
  http://www.who.int/patientsafety/worldalliance/en/

- **Launch of the Global Patient Safety Challenge**
  http://www.who.int/patientsafety/events/05/global_challenge/en/index.html

- **Technical activities**
  http://www.who.int/patientsafety/activities/en/

- **Information centre**
  http://www.who.int/patientsafety/information_centre/en/

- **Patient Safety News**
  http://www.who.int/patientsafety/en/

- **Events**
  http://www.who.int/patientsafety/events/en/index.html

Events and Conferences in late 2004 and 2005

**Alliance Day**
Shanghai, China, 18 September 2004
The first Alliance Day for the WHO World Alliance for Patient Safety took place on 18 September in Shanghai after the WPRO Committee meeting.

**International Workshop on “Methodologies for estimating patient Harm”**
Amsterdam, The Netherlands, 18–19 October 2004
The World Alliance for Patient Safety convened a two day meeting around the theme “research methodologies to estimate patient harm in developing and transitional countries”.

**The Launch of the World Alliance for Patient Safety**
Washington DC, USA, 27 October 2004

**Intercountry Consultation for developing a regional strategy For Patient Safety in the Eastern Mediterranean Region of WHO**
Kuwait, 27–30 November 2004
The Eastern Mediterranean Regional Office and the Executive Board of the Health Ministers’ Council for Gulf Cooperation Council States organised an intercountry consultation for developing a regional strategy for patient safety in region.

First International Consultation on Hand Hygiene in Health Care Settings
Geneva, Switzerland, 3 December 2004
Global Patient Safety Challenge for 2005-2006: Clean Care is Safer Care
The Consultation examined a number of existing WHO and other international and regional strategies and guidelines in the areas of hand hygiene and infection prevention.

Regional meetings of World Alliance for Patient Safety
Organized in association with the Ministries of Health of Kenya and South Africa, non-government organizations such as the Council for Health Service Accreditation of Southern Africa, and WHO. Meetings aimed to build awareness on the safety of care in African countries and the commitment of interested countries, current and potential agencies and many other partners to improve patient safety.

Core Group Meeting of Experts: International Consultation on Hand Hygiene in Health Care Settings
Geneva, Switzerland, 10–11 March 2005
A group of international experts on infection prevention and control gathered at WHO Headquarters in Geneva to review the draft WHO guidelines and reach consensus on unresolved issues or designate special task force groups to resolve the issues.

Patient Safety - Making it happen - The European perspective
Luxembourg, 4-5 April 2005
A conference held under the auspices of the Luxembourg EU Presidency and the European Commission. The purpose of this conference was to ensure that patient safety has a firm place on the European agenda so that all the European actors can work together to make it a reality.

World Health Care Congress-Europe
Keynote address by Sir Liam Donaldson on “Tackling patient safety: an international challenge”
Paris, France, 8 April 2005
World Health Care Congress-Europe
Chantilly, France, 14-15 April 2005
Conference brought together over 400 executives from the key organizations that are advancing health care in Europe and focused on global best practices for improved health care delivery and outcomes. Sir
Liam Donaldson delivered a keynote address on: “Tackling patient safety: an international challenge”

**Patient Safety as a European Challenge**
Warsaw, Poland, 14-15 April 2005
Conference organized by the Polish Ministry of Health within the Polish Presidency of the Council of Europe. The new Recommendation of the Council of Europe on patient safety and quality management - systemic approach - were introduced. Sir Liam Donaldson attended as keynote speaker.

**10th European Forum on Quality Improvement in Health Care**
London, United Kingdom, 15 April 2005
The forum aims are to provide education on how to improve health care, exchange sound, practical ideas on improving health care, provide a setting for deep discussion and shared learning among those charged with leading improvements in health care. Sir Liam Donaldson attended as keynote speaker.

**1st Middle East Conference on Prevention and Management of Healthcare-related Infections**
Riyadh, Kingdom of Saudi Arabia, 21-25 May 2005

**The Health Professions and Patient Safety**
Geneva, Switzerland, 16 May 2005
A lunch-time event focusing on Patient Safety organized by the International Council of Nurses (ICN) to coincide with the 58th World Health Assembly.

**Patient Safety Briefing at Geneva’s University Hospitals**
Geneva, Switzerland, 17 May 2005
A presentation by Sir Liam Donaldson to over 100 health care professionals.

**Informal Briefing at World Health Assembly**
Geneva, Switzerland, 19 May 2005
An informal briefing at the Palais des Nations on the Global Patient Safety Challenge

**IHI’s 1st Annual International Summit on Redesigning Hospital Care**
San Diego, CA, 8 June 2005
The 1st Annual International Summit on Redesigning Hospital Care was a convergence of Institute for Healthcare Improvement’s Summits on critical care, patient safety, flow, and workforce development. This event aimed to help all areas of a hospital come together and design a unified plan for making sustainable improvements for patients.

**HOPE: Exchange Programme for Hospital Professionals Evaluation Meeting & Conference**
Cardiff, Wales, June 2005
The Hope Exchange Programme provides an opportunity for health managers and professionals to spend four weeks on placement in another European country, with an emphasis on studying organization and management issues. An evaluation meeting, to which all health professionals of the 2005 HOPE Exchange Programme were invited, took place from 22 to 26 June 2005 in Cardiff on the theme of “Patients’ Safety”.

**The Quality Colloquium**
Cambridge, M.A., USA, August 2005
An Executive Education Course on Patient Safety, Healthcare Quality Enhancement and Medical Errors Reduction for Healthcare Executives, Clinicians and Patient Care Staff took place on 21-24 August 2005

**Launch of WHO Collaborating Centre on Patient Safety Solutions**
Washington, D.C., USA, 23 August 2005
The World Health Organization designated the Joint Commission on Accreditation of Healthcare Organizations and Joint Commission International (JCI) as a WHO Collaborating Centre on Patient Safety Solutions dedicated to patient safety solutions.

**Core Group Meeting of Experts: International Consultation on Hand Hygiene in Health Care**
Geneva, Switzerland 25-26 August 2005

**The Second National Conference on Patient Safety: From Words to Action**
15-16 September 2005
Two day conference discussing methods and experiences on how to prevent injuries and increase the quality in health care.

**8th European Health Forum**
Gastein, Austria, 5-8 October 2005
The main topic for the EHFG 2005 was “Partnerships for Health”. Sir Liam gave a keynote speech during the plenary session entitled: European health and partnership challenges.

**The Launch of The Global Patient Safety Challenge 2005-2006: Clean Care is Safer Care**
WHO, Geneva, Switzerland, 13 October 2005
The first meeting of the Drafting Group of the (IPSET) Project brought together experts in patient safety and classification systems from around the world to meet and discuss the formation of a globally agreed IPSET.
ISQua’s 22nd International Society for Quality in Health Care  
Vancouver, Canada, 25-28 October 2005  
Three-day conference with a major focus on Patient Safety, including a presentation on the World Alliance for Patient Safety.

The Oxford Health Alliance 2005 Meeting: Patient Safety Seminar  
Patient Safety: the Global Challenge  
Yale School of Medicine, New Haven, CT, 31 October 2005

Commonwealth Fund Symposium: Informal briefing and reception on the World Alliance for Patient Safety  
Washington, DC, USA, 2 November 2005

Knowledge is the enemy of unsafe care  
1st Meeting on the Global Research Program for Patient Safety  
WHO World Alliance for Patient Safety in collaboration with AHRQ  
Washington, DC, USA, 1 November 2005

Capitol Hill, USA: Speech by Sir Liam to a Panel at the US Congress on the patient safety agenda in the UK  
Washington, D.C., November 2005

Patients for Patient Safety Meeting  
London, United Kingdom, 27-30 November 2005  
Patients for Patient Safety, one of six action areas of the World Alliance is hosting a workshop for patients and consumers. The workshop will run in conjunction with the EU Summit on Patient Safety.

Patient Safety Summit  
London, United Kingdom, 28-30 November 2005  
Hosted by the UK as part of the UK Presidency of the EU.

World Alliance for Patient Safety Day  
Moscow, Russian Federation, 9 December 2005  
An annual event which aims to report on progress achieved during the last year and to look at new action areas for the year ahead. Technical progress made at regional level will be highlighted with a particular focus on the Commonwealth of Independent States (CIS) and Baltic countries.

Institutionalization of Patient safety Workshop  
Moscow, Russian Federation, 10 December 2005

Articles

3. Donaldson L, When will health care pass the orange wire test? The Lancet 2004, 364; 1567-1568  
7. Donaldson L, Clean Care is Safer Care: a worldwide priority The Lancet 2005, 366: 1246-1247  
THE PATIENTS WE HAVE WORKED WITH, OVER THE PAST YEAR, HAVE TOUCHED OUR HEARTS AND MINDS. WE HOPE TO BE ABLE TO DELIVER THEIR HOPES AND EXPECTATIONS TO MAKE CARE SAFE IN EVERY CORNER OF THE WORLD