



Patients for Patient Safety News

February 2009



Welcome to the first PFPS News of 2009! This edition highlights champion activities in Egypt, brings news of patient safety work around Education and Technology, along with more information on the Save Lives Clean Your Hands Campaign, and much more!

EMRO Feature



Activities in Egypt

Nagwa Metwally, Patients for Patient Safety Champion, Egypt

This year I am really happy and I started to feel a bit of satisfaction and some reward from the hard work of the past four years. There is now huge awareness, you feel it everywhere in the hospital, from the management to all the staff, this the third management in the hospital we are working with, and I think the best as they have a good will for change and we are working together very well exchanging views and adopting solutions and following them together. Below are two of the important issues showing the great change happening in the hospital currently;

- The general manager of the hospital Dr Rami, established an important committee reporting directly to him for quality control headed by a very efficient lady doctor, Dr Azza AWAD she is very enthusiastic and a good champion for patient safety and a very high believer in the importance of change in the hospital and we are working together in all details discussing, suggesting and following up with her and evaluating every step together.
- A new infection control plan is being implemented. Now the head of infection control in the hospital is another very good lady doctor, Dr Gada Ismail, she is a wonderful person and another very good champion for patient safety with a very good vision and she knows well what to do and we are always in consultation together with the management in all the details and my group is helping as an outsider eye in observation and following up the implementation of the plan.
- Third, this year we are improving the infrastructure of 5 old theatres and creating 4 new theatres which will cost 2 million, 4 hundred Egyptian Pounds. It is a huge project but I managed to find the funding and they will finish in two months. This will make a big change in the safety of the patient plus we are providing what is needed to help to find more fund raising for the equipment.

To find out more you can email Nagwa at: nagwametwally@hotmail.com



Alexandria Patient Safety Alliance

Dr Damaty, Patients for Patient Safety Champion, Egypt

It is our pleasure to announce the formation of the Alexandria Patients Safety Alliance (APSA). The APSA is formed of an alliance between the various healthcare stakeholders in Alexandria Governorate. They include the University of Alexandria, Ministry of Health and Population, Medical Insurance Organization, Private Hospitals, Patients and Community members. The APSA 's vision is to work towards safe and friendly hospitals with staff that listen, learn and respond collaboratively to ensure patient safety and dignity. This is an open invitation to all of those who are interested in patient safety to join the alliance so we can work together to achieve a safer environment for our patients in our governorate and beyond.

Continued on page 2...

What's inside?

- Patient Safety Friendly Hospital in Egypt
- Education work in Italy
- Results from Safe Surgery pilot study



APSA Declaration:

We, the Alexandria Patient Safety Alliance (APSA) aim at promoting safe healthcare. We are committed in making our hospitals safer by minimizing the risk of harm to our patients. The APSA in its formation will ensure participation of the different healthcare stakeholders including patients and community members. We, are committed in achieving our aims through ethical and scientific means that preserve patient dignity and produce valid evidence that is shared in a transparent environment.

We, will work collaboratively in creating a critical level of awareness on patient safety in our community. We, will also foster a culture of learning and understanding from adverse events and encourage confidential reporting of healthcare errors to help focus efforts on error prevention and correction rather than individual or organization culpability.

We, will jointly promote sound clinical practices through the implementation of safety programs and institutional capacity building and through targeted programs based on stakeholders needs. We, will encourage educational and professional bodies to include patient safety in their curricula and professional development programs. We, will create constructive dialogue with other parties wishing to enhance patient safety within their healthcare setting.

To find out more you can email Dr Damaty at: mmdamaty@yahoo.com



Patient Safety at Shark El-Madena Hospital and the Patient Safety Friendly Hospital Initiative



Dr Damaty, Patients for Patient Safety Champion, Egypt

While errors in individual medical practice contribute to patient harm, the underlying root causes are design of health systems, management, environmental and operational factors, organizational design and communications. In this regard, Patient Safety should be viewed from a systems perspective and strategies must be based on system changes that overhaul the culture and approach to quality and safety rather than targeting of individual practitioners. Below are some examples of how improvements can be made in patient safety through the Patient Safety Friendly Hospital Initiative (PSFHI), which ensures compliance of hospitals to involve consumers in improving health care safety through a performance assessment instrument drafted by WHO/EMRO. PSFHI demands Patient and Public involvement when the hospital performance is assessed and certified.

Hospitals build health literacy for its patients and carers to empower them to make the right decisions in their care; this involves community in different patient safety activities and verification and the hospital communicates patient safety incidents to patients and their carers; ultimately the hospital has a patient friendly environment.

The purpose of organizing safety programmes is to ensure that the conducive environment created by the national level policies are realized at the facility level. The lessons learnt from reviewing PS in EMRO show that at the same time that the MOH is developing its policies for Patient Safety, there is need for bottom up plans at the facility level.

The aim is that all patients participate in making decisions regarding their health care. The informed consent is one example of this, and which should include: 1 – All possible minor and major complications as well as; 2 – The illustrated steps of any operation or intervention. Patients or their carers should sign consent before any risky procedure. He / she should be informed of all the risks, pros and cons of procedure.

Other examples of patient friendly initiatives at the Shark El-Madena Hospital:

- The Managers home, mobile and office numbers are displayed all over the hospital for internal and external customers
- Complaints boxes are displayed for internal and external customers
- Patients rights / duties posters displayed

Continued on page 3...





The table below indicates figures related to hospital acquired infection before and after the changes were made;

Item	2007	2008
Total Number of Patients operated (Open cardio-thoracic surgery)	290	304
Mean L.O.S of all patients	7.9	6.2
%of reduction of average L.O.S		21.5
No of infected cases	12	7
Infection rate	4.1%	2.3%
% of reduction of infected cases		41.6%
Mortalities due to infection	4	1
% of reduction of mortalities		75%

**cost of infection control in
Shark El Madina Hospital 2007**

**Total Cost of IC activities 392,911 L.E. Total
Hospital Expenditure 18,670,324 L.E.**

**SO:
Cost of IC activities= 1.5 % of hosp. Exp**

CONCLUSIONS: Applying the Patient Safety Friendly Hospital Initiative will lead to great improvements in hospital outcomes in all aspects.

To find out more you can email Dr Damaty at: mmdamaty@yahoo.com

NEWS FROM PAHO

Mexican Patient network

Alexo Esperato Martinez, Quality of Health Services, PAHO

"The journal of the Comisión Nacional de Arbitraje Médico (CONAMED) devotes the title page of its last issue (Oct-Dec 2008) to the Mexican Patients for Patient Safety Network. This issue contains a 13-page article about the Mexican Network authored by the Network's organizing committee. The article depicts the origins and strategic framework (mission, vision, objectives, and activities) of the Mexican Network, as well as providing a description of World Alliance for Patient Safety/PFPS program from its very first activity--the Global meeting in London (2005). The article provides information about past and future activities of the Mexican Network's members, including healthcare infections and previous campaigns on health literacy in indigenous communities.

On January 28th, the Ministry of Health and Mexico country office of the Pan American Health Organization arranged a high-level meeting in Mexico City. The meeting had the objective of launching a joint patient safety program with Cuba. In this meeting, Evangelina Vázquez, Coordinator of the Mexican and Pan American Patient Networks and PFPS Champion, presented both networks to Cuban representatives and officials of the Quality Program at the Ministry of Health. This meeting, intended to be a first step in a collaborative patient safety framework for the Caribbean, finished with the definition of joint objectives and next steps. "



Changing Culture: One Patients' Experience

Leslie Worthington, PFPS Champion, Canada

I have been fighting for patient safety, including full disclosure of and apology for medical errors, in Winnipeg, Canada, since my Dad's death on January 26, 2004. His death was a combination of negligence, bad decisions, and medical errors by the Hospital. Symptoms of a heart attack brought my 79-year-old Dad, John Klassen, to the Hospital emergency department on October 29, 2003, where he was left medically unattended for 35 minutes despite our pleas for help. My Dad suffered severe brain damage and he never walked again, had to be tube fed and did not recognize his family. He was transferred too late to another hospital for emergency cardiac care, urgently needed diagnostic tests repeatedly failed to be performed and needed medications not administered.

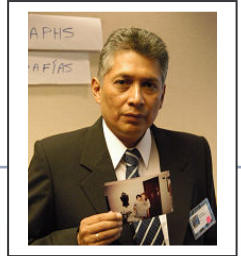
Determined to learn what really happened and why, I appealed to the Winnipeg Regional Health Authority to investigate my complaints while I continued to meet with Henry Tessmann, COO of the Hospital. Finally, two years later Henry Tessmann told me they were sorry for what happened to my Dad. More than four years later, in July 2008, my Mom received compensation.

Henry Tessmann and I agree that my family and the Hospital were polarized. When a risk of litigation is brought to the Hospital, the lawyers assume the process of dealing with patients and families and that gets in the way of understanding and dealing with issues and concerns. We agree that we were not on the same side which added to our pain.

That was then and this is now. The test came when my 57-year-old brother, Laverne, died from a massive heart attack on June 6, 2008, at a Cardiac Hospital in Winnipeg after being transferred from the same Hospital where my Dad died. We were paralyzed that we were in the same hospital; same resuscitation room; and some of the same staff. When I was first told my brother had been taken to the same Hospital my family and I were extremely apprehensive. Was there anything different about the way the staff responded to me and my family this time? Absolutely. When the staff realized that this was my brother they responded to the situation by being caring and compassionate, never leaving our side until my brother was transferred to the Cardiac Hospital. Henry Tessmann appeared in the ICU to comfort my family. They openly acknowledged what my family had gone through. It was as if the past was put behind us.

Tessmann and I agree that the ship of culture change turns very slowly, but by working together the Hospital is on an improvement journey.

If anything positive came out of my ordeal in the aftermath of my Dad's death at the Hospital, it is the transformation of Henry Tessmann. He is listening to patients, families and staff. For the last two years I've asked him to sponsor a patient to attend a patient safety conference and he does. I give him credit; if anybody has made a big change, it's him. To date, we continue to work together always looking for ways to improve patient safety.



Progress in Peru

Alfonso Maldonado, PFPS Champion, Peru

In 2008 I have been trying to spread the voice and raise awareness about the World Alliance for Patient Safety by giving presentations to nurses in some of Lima's largest hospitals.

I have been offering talks to nurses with the objective of raising awareness about patient safety and to help nurses understand that their work is so important from the human point of view, and also that they can make a difference through their work and achievements. Such is the case for Julio Mendiguren, a member of my group, who has been successful in raising awareness around new issues, and his work is appreciated, and last month he participated as a candidate to become Dean of Peru's College of Nurses. This has made us stronger, and provides us with possibilities for future progress.

I also worked as an anonymous facilitator in the Medical Federation of Peru's strike in which there was a strong division between Doctors and the Minister of Health, and this involved a personal meeting with the President of the Federation, Dean of Lima's medical college and the delegates, and after 2 hours I was able to convince them to seek a solution for the good of the patients.

My time is very tight, but we have been building a path, communicating with the diverse representatives of the medical associations trying to overcome the challenges. Peru's doctor – patient scene is changing a lot, and I hope we can advance much more this year.



CHAMPIONS FROM EURO



Education work in Perugia

Silvana Simi / Lucio Patoia, Patients for Patient Safety Champions, Italy

A Continuing Medical Education course on “The improvement of clinical practice and patient safety” took place on Friday 19th December in Perugia (Italy), addressed to healthcare professionals. Lucio Patoia, one of the three Italian PFPS Champions was the organizer and one of the speakers, and another Champion, Silvana Simi was invited to give a talk as well.

It has been a great opportunity to bring again the patient’s voice into a professional environment, such as the Italian one, not much used to looking at the patient as a full partner in all the process of health care.

The talks mainly focused on Evidence Based Continuing Education to promote an Evidence Based Practice and consequently to improve the appropriateness and effectiveness of clinical activities and the safety of patients. The final round table focused on the hurdles to a proper clinical practice from the point of view of the NHS management, the nurses, the Quality Services and patients.

While Lucio pinpointed the types and directions of the relationship between continuing education and clinical practice in Italian hospitals, Silvana continued to offer the patient’s perspective, and had the opportunity to stress that health is more than numbers and beyond numbers, acronyms and statistic there are persons whose lives are affected by diseases and sometime by errors and malpractice.

This experience has further confirmed that, at least at Italian level, to have as PFPS Champions also healthcare professionals, such as medical doctors particularly committed to the “person-centred-medicine” and able to work together with “lay” PFPS Champions, helps a lot to develop strategies to empower patients and to increase public involvement and awareness in health care and social care decision making.

For more information email Silvana at a.simi@ifc.cnr.it



Patients for Patient Safety Champion presents at Strategic Health Authority meeting, UK

Yasmin Khan, Patient Safety Action Team, North East NHS, UK

Mike Casselden, Patients for Patient Safety Champion in the UK, spoke at a meeting this month entitled: **Patient, Carer and Public Involvement in Safer care North East**. There were 31 people who attended which was a fantastic turnout. There was a good mix of people from across the North East region.

The purpose of the meeting was to give an overview of the North East region Patient Safety Strategy, which we have called 'Safer Care North East'. This strategy focuses on 8 particular 'task groups' and other key areas to help support the improvement of patient safety such as looking at Patient Safety Culture. To give an overview of the national patient safety champions network (Mike gave a verbal update and the presentation was included in the delegate’s packs), to discuss the opportunities for people to get involved in Safer Care North East and to agree a way forward after the meeting.

Main discussions;

- 2 way communication needed
- need to include social care in this work
- draft structure (see diagram) about who and
- which organisations that are involved
- this needs to be a 2 way process at all levels,
- maintaining links nationally
- Patient/Public involvement needs to make a difference - don't want this to be a 'talking shop'
- all agreed a regional Safer Care Patient, Carer and Public Engagement Network is a positive way forward
- People expressed their interest to join specific task groups and / or a regional network
- The next meeting will take place in April

More information can be found at: www.northeast.nhs.uk/what-were-doing/patient-safety



World Alliance for Patient Safety



Technology and Patient Safety

Sara Yaron Patients for Patient Safety Champion, Israel

Two Patients for Patient Safety Champions are involved with the important World Alliance for Patient Safety, Technology for Patient Safety programme. We're working together with professionals all around the world, in order to publish a paper regarding this issue. In these early stages we have so far been involved in two teleconferences, in which we have discussed many issues that have been raised by our working group whose focus is on how to make existing technology safer.

The fact that patients are involved, working hand in hand with professionals and policy makers, from the start, is a big and important step toward partnership regarding safe health care.

For more information email Sara at aron-i@bezeqint.net



World Alliance for Patient Safety – 2nd Global Patient Safety Challenge: Safe Surgery Saves Lives Surgical Adverse Events reduced by one third in trials in eight countries

Hospitals in eight cities around the globe have successfully demonstrated that the use of a simple surgical checklist, developed by WHO, during major operations can lower the incidence of surgery-related deaths and complications by one third. The studies were undertaken in hospitals in each of the six WHO regions. Analysis shows that the rate of major complications following surgery fell from 11% in the baseline period to 7% after introduction of the checklist, a reduction of one third. Inpatient deaths following major operations fell by more than 40% (from 1.5% to 0.8%).

"The concept of using a brief but comprehensive checklist is surprisingly new to us in surgery. Not everyone on the operating teams were happy to try it. But the results were unprecedented. And the teams became strong supporters," said Dr Atul Gawande, main author of the study and team leader for the development of the WHO surgical safety checklist.

Data was collected from 7688 patients. The study was carried out in hospitals in both high and lower income settings—in Tanzania, Philippines, India, Jordan, United States of America, Canada, United Kingdom and New Zealand. The reductions in complications proved to be of equal magnitude in high and lower income sites in the study. ***"These findings have implications beyond surgery, suggesting that checklists could increase the safety and reliability of care in numerous medical fields,"*** Dr Gawande said. It requires only a few minutes to complete at three critical points during operative care – before anaesthesia is administered, before skin incision and before the patient leaves the operating room. It is intended to ensure the safe delivery of anaesthesia, appropriate prophylaxis against infection, effective teamwork by the operating room staff and other essential practices in perioperative care.

"The immediate response to the checklist has been remarkable, and the studies undertaken in the pilot hospitals are significant. They will make a major contribution towards our goal of having 2500 hospitals around the world using the safe surgery checklist by the end of this year," said Sir Liam Donaldson, Chair of the WHO World Alliance for Patient Safety and Chief Medical Officer for England.

The results of the study are published on the web site of the New England Journal of Medicine. The material appeared in the journal's printed issue on 29 January 2009. For more information please contact Vivienne Allan, allanvi@who.int



Other Patient Safety News

European Commission takes steps to promote patient safety in Europe

Graham Tanner, Patients for Patient Safety Champion, UK

On 15 December 2008 the European Commission published proposals to improve patient safety in Europe. The key proposals were; establishing or strengthening reporting & learning systems, embedding patient safety in the education and training of healthcare workers, involving patients in the development of safety measures, providing patients with relevant information on health risks and safety issues. A summary of the press release is below;

Each year, in the EU, between 8% and 12% of patients admitted to hospitals suffer harm from the healthcare they receive, including from healthcare associated infections. Much of that harm is preventable. Most efforts to improve patient safety at Member State and EU levels have so far focused on specific causes, for example, minimising the risk from medicinal products, medical devices or antimicrobial resistance. However, most adverse events are caused by a combination of factors which together result in harm to the patients.

"...Patient Safety is the cornerstone of good quality healthcare. I would like to see a Europe for patients where safety is paramount and citizens are confident and knowledgeable about the care they receive." **Androulla Vassiliou, EU Commissioner for Health**

Following a public consultation on patient safety earlier in the year, the Commission recommends a comprehensive approach to improving patient safety. Key recommendations for Member States include: establishing or strengthening reporting and learning systems; embedding patient safety in the education and training of healthcare workers; involving patients in the development of safety measures; and providing patients with relevant information on health risks and safety issues. Member States are also encouraged to share best practice and expertise in this field.

Recent studies have shown that healthcare associated infections can be reduced by up to a third when certain infection prevention and control measures and structures are put in place. Therefore, the proposal includes a particular focus on healthcare associated infections. Recommendations include: specific measures to prevent and control infections; ensuring that infection prevention and control is enhanced in hospitals; and having effective systems in place to detect and report infections.

The full press release can be found at; http://ec.europa.eu/health/ph_overview/press_overview_en.htm



IAPO calls on WHO member states to protect patients from counterfeit medical products

The International Alliance of Patient's Organizations (IAPO) recently urged members of the WHO Executive Board and member states to protect patients from counterfeit medical products by taking action to promote awareness of the dangers they pose. This request was at the core of an intervention made by Jeremiah Mwangi, IAPO Senior Policy Officer, addressed to delegates at the 124th session of the WHO Executive Board in Geneva, Switzerland.

Counterfeit medical products pose a very real threat to the lives of patients worldwide, and are one of many threats to the quality and safety of medicines available to patients. IAPO believes that the prevalence and availability of counterfeit medical products highlights the gross inequity in access to safe and effective medical products that exists around the world.

To meet this challenge, numerous factors must be addressed, including weak regulatory systems, inability to afford essential medicines, lack of alternatives and a lack of information. Counterfeit medical products are a public health issue. Therefore, IAPO believes that WHO has a central role to play, bringing together relevant stakeholders, including other specialized UN agencies, who can tackle this threat.

IAPO made the following call to delegates: *"In WHO and member states actions to protect the public from counterfeit medical products, we ask you to not only promote awareness of counterfeit products among health professionals, but also among patients so that they can be vigilant and report suspect medicines. IAPO believes that is essential to take comprehensive and coordinated action to communicate the risks of counterfeit medical products to patients, and to keep patients safe."*

The International Medical Products Anti-Counterfeiting Taskforce (IMPACT) estimates that: *"Many countries in Africa and parts of Asia and Latin America have areas where more than 30% of the medicines on sale can be counterfeit."* This demonstrates in stark terms the need for political commitment and the full energy of those global institutions designed to protect and promote public health to combat this problem. This critical public health issue must not be allowed to slip off the agenda.

For further information please contact Jeremiah Mwangi; jeremiah@patientsorganizations.org



FORTHCOMING EVENTS

Save Lives Clean **Your Hands 5 May 2009**

Raising the Profile of Hand Hygiene at the Point of Care

This year, on 5 May, the WHO Alliance for Patient Safety's First Global Patient Safety Challenge: Clean Care is Safer Care is embarking on a major new exercise to motivate 5000 hospitals and healthcare organisations around the world to sign up to improving hand hygiene at the point of care.

Taking country pledges to the bedside puts it in a nutshell, says project lead Dr Cyrus Engineer. 'We are aiming for 5000 registrations by 5 May 2010. It is an ambitious undertaking, however we are confident of success.'

The first step is to revise the current hand hygiene toolkit. A team of technical experts led by Julie Storr is working on this task. Completion date is mid March to allow for translation into French and for hard copies to be printed and distributed to countries where access to the internet is infrequent or difficult. At the same time a new self-assessment framework for healthcare facilities is being developed. It will also be available in hard copy.

'These tools will be launched on 5 May via a new microsite that will be part of the existing Challenge site,' says Cyrus. 'We are very aware of the need for printed copies to be available and timing is critical to make sure everything is ready in time.'

Already 134 hospitals from 33 countries have registered interest in the project. Early analysis of the information they have provided suggests this equates to 188,063 staff to whom the importance of hand hygiene at the point of care can be disseminated. With more than 64,255 beds, this represents a lot of patients.

'We want to spread the word', says Cyrus. 'Practicing hand hygiene at the point of care saves lives. Our vision from now until 2020 is to encourage more country campaigns, to promote awareness of the critical importance of hand hygiene, and to stimulate interest not only among healthcare workers but patients as well.'

On 5 May this year Geneva will also host a 2-day technical meeting for countries who have an existing hand hygiene campaign and for countries who are in the process of developing a campaign. More details about the day will be available soon.

**More information
in the next
edition**

More information on this project can be found at the following;
<http://www.who.int/gpsc/5may/en/index.html>

We really want to hear about all the important work you are participating in, so please don't forget to email Anna at leea@who.int if you have any news you want to share or events you want to alert others to.

The next edition of PFPS News will be sent in April, so please send any contributions through before 25th March 2009. Many thanks.