Methods and Measures for Patient Safety Research

1st Expert Consultation meeting
18-19 December, WHO, Geneva, Switzerland

Introduction

Patient safety has received increased attention in recent years mostly with a focus on the identification of errors and adverse events. A number of methodologies have been proposed with this purpose. Among them, the most visible and influential research has focused on assessing the prevalence of adverse events in hospital care settings using retrospective record review. Other important methods encompass spontaneous active reporting, direct observation, automated detection of adverse events using information technologies, and others. Each methodology respond to different purpose and are applicable in different contexts. Each have their own strengths and weaknesses.

The WHO World Alliance for Patient Safety recognizes that to advance the understanding of patients risks and hazards, and to design and implement effective solutions, research must use the best existing methodologies in the most appropriate manner. Furthermore, the Alliance recognizes that research has advanced less in many areas of enquiry and in health care settings due to the lesser availability of valid methodologies, and to the limitations of the existing ones. Additionally, the richer experience derived from other industries shows the potential for patient safety research from a larger array of methods not yet widely used in health care.

The goal of the World Alliance for Patient Safety's working group on methods and measures for patient safety research is to identify and recommend specific directions to the WHO World Alliance for Patient Safety leading to the advancement of research methodologies and measures and to the adoption of the most appropriate ones for specific contexts.

Terms of Reference for the Working Group

The Working Group on Methods and Measures is to identify methods and measures for assessing patient safety in specific settings. By late spring 2007, the Working Group will identify useful methods and measures with an emphasis on (1) acute care settings and (2) community-based care with a specific focus on primary care and describe areas where additional work may be needed such as long-term care. The Working Group will consider methods and measures that are applicable in higher income countries and those useful in lower income countries. The primary focus will be on outcome measures rather than measures of
healthcare structure or processes of care. However, we will consider not only measures of events and activities, but also measures of errors and near misses and components of the work environment and culture that may reflect underlying conditions that facilitate safer care. Two background papers will be developed reviewing selected measures and methods that have been found helpful, one for acute care and one for community based care. These papers will identify the measures, the strengths and weaknesses of the measures and the methods used to collect them, identify key literature on these measures, and where possible, also identify selected key organizations that have developed and/or used these measures, including both healthcare delivery organizations and regulatory or accreditation agencies. The Working Group will use this papers to make recommendations about these areas. In addition, the Working Group will identify some of the gaps that need to be addressed regarding measures to assess patient safety, with respect to contents areas, development, and use of measures.

**Output**

A document recommending specific research methods for a range of patient safety research questions, settings and contexts with a particular emphasis on developing countries

The final output will be submitted for consideration to the Research Council of the WHO World Alliance for Patient Safety.