WHO Activities on Patient Safety & Quality Improvement

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Outline of the Presentation

- Service Delivery and Safety Department
- Patient safety - a global agenda for action
  - Burden of unsafe care
- Patient Safety and Quality Improvement (PSQ) mission and work streams
  - Research
  - Challenge and campaign
  - Education and training
  - Implementing change
  - Patient engagement
- PSQ priorities 2015
Emerging Areas and New Projects
- Universal Health Coverage Service Delivery Task Force
- Global Challenges and Campaigns

Patient Safety and Quality Improvement (PSQ)
- Institutional partnerships
- Tools for safety and quality, checklists
- Patient and family engagement
- Global networks, Injection safety
- Infection prevention and control
- Patient safety education and training

Traditional and Complementary Medicine (TCM)
- Structures and delivery models of TCM and integration
- TCM policy development and regulation
- Evidence, research & technical guidance
- Education and training in TCM
- Best practices, resources on safety, quality and people-centredness of TCM

Services Organization and Clinical Interventions (SCI)
- Health services continuum – hospitals, primary care, service delivery
- Health services integration & people-centredness
- Regulation and accreditation
- Blood safety
- Essential and emergency surgical care
- Transplantation
What is Patient Safety?

Patient safety is

- The absence of preventable harm to a patient during the process of health care
- A component and a result of good quality health services and quality of care
- Improved health outcomes and health status
Why Patient Safety?

- 1 in 10 patients harmed in hospital care
- 14 out of every 100 patients affected by HAI
- 2% patients subject to surgical complications for the 234 million surgical operations performed every year
- 6.3 events per patient day in the US annually due to medical devices
- 20-40% health spending wasted due to poor quality of care and safety failures
IBEAS Report 2011

Source: IBEAS, a pioneer study on patient safety in Latin America, Towards safer health care, WHO, 2011
"Using a conservative approach, we estimated that there are at least 43 million injuries each year due to medical care, and that nearly 23 million DALYs are lost as a consequence."

## Costs Associated with Safety

### Summing what
- Additional hospitalization
- Litigation costs
- Infections acquired in hospitals
- Disability
- Lost productivity
- Medical expenses

### How much
- Costs associated with safety failures run into several billion dollars annually
- Costs associated with HAI run into US$7-8.2 billion annually in US, €800 million in UK and France, US$48 million in Turkey
- Costs associated with unsafe injections run into US$535 million direct medical costs
Patient safety is a serious public health issue

<table>
<thead>
<tr>
<th>Event</th>
<th>Probability</th>
</tr>
</thead>
<tbody>
<tr>
<td>Chance of a traveller being harmed while in an aircraft</td>
<td>1 in 1,000,000</td>
</tr>
<tr>
<td>Chance of a patient being harmed during health care</td>
<td>1 in 300</td>
</tr>
</tbody>
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WHO and Patient Safety

- 2002: WHA55.18 resolution: Quality of care-patient safety
- Since 2004:
  - over 140 countries have worked to address challenges of unsafe care
  - WHO Patient Safety grew into a multi task program working with a health system perspective
The mission of the Patient Safety and Quality Improvement (PSQ) Unit to:

- provide **global leadership and strategic direction** on matters critical to patient safety and improvement of quality and safety of health services

- set norms and standards, and define and promote **best practices** towards ensuring patient safety and quality and safety of health services, within the context of **people-centred delivery of services**

  • emphasizing a primary health care orientation
WHO Patient Safety

- Currently working on 13 priority action areas
- Organized under 5 main work streams
  - Research
  - Campaigns
  - Education and training
  - Implementing change
  - Patient engagement
Patient Safety Research

- **Strengthening capacity for patient safety research**
  - Guide for developing training programs
  - Core competencies for patient safety researchers

- **Methods, measures and tools**
  - Methodological guide for data poor settings
  - Patient safety in primary care
  - Rapidly assessing hazards
  - Human factors tools

- **Generating data & research small grants**
Global Patient Safety Challenge and Campaign

Clean care: ‘Save lives: clean your hands’

- The first patient safety challenge
- 136 Member States and autonomous areas pledged support
- 5 May 2015 campaign theme: Strengthening health care systems and delivery ‘hand hygiene is your entrance door’

Safe surgery: ‘Safe surgery saves lives’

- The second patient safety challenge
- WHO guidelines on safe surgery and surgical checklist
- Pulse oximetry project
Education and Training on Patient Safety

- **Development of Leaders' Guide on safety and quality of service delivery**
  - Leadership competencies Framework developed

- **Standardization in health care and patient safety development**
  - Completion of *High5s* Project;
    - standardization in health care and testing SOPs
    - Synthesis of 5 year data from 150 hospitals of 7 participating countries
    - Final report completion
    - Medical faculty workshop
Implementing change
Patient Safety Measures and Solutions

- Reducing blood stream infections
- Information model for patient safety
- Reporting and learning systems
- Hand hygiene implementation tools
- Patient safety checklists
  - Safe surgery checklist
  - Safe childbirth
Reporting and Learning Systems for Safety in Health Care

EC-WHO Minimal Information Model (MIM) Project

- Concept 'Minimal Information Model for Patient Safety'
- Ongoing surveys
- International consultation, May 2015, Poland

HIS Ideas Bed on MIM project

- Mapping of existing systems
- Pilot studies in Morocco and India

Patient safety

EU Validation of Minimal Information Model for Patient Safety Incident Reporting

Things go wrong in health care with unacceptable frequency for individuals seeking health services, whether for preventive, diagnostic, curative or rehabilitative services. When an “adverse event” occurs, it is essential to understand the causes and contributory factors, as well as the consequences, and the possible mitigating actions and solutions which could prevent the event from happening again.

In collaboration with the European Commission’s Directorate-General for Health & Consumers (DG-SANCO) WHO invited institutions in various EU countries to collaborate with testing a MIMPS draft template developed by WHO, provide feedback and suggest possible modifications, as well as to collaborate on exploring methods for extracting a common learning dataset from existing patient safety reporting systems.

Expected Outcomes

The overall expected outcomes of the project are:

- A validated template (Minimal Information Model for Patient Safety Reporting and Learning) with User Guidelines.
- A set of preferred terms to denominate and define the main types of patient safety incidents.
- An EU-wide feasibility assessment, summarizing the features required by EU countries to adapt their reporting systems to, or to build new ones, based on MIMPS.
- Guidance for best practices to elicit learning from reporting systems.

Project Presentation and Project Launch

The project was officially launched on 23 January 2014 in Brussels, in an event hosted by DG-SANCO and the Subgroup on Reporting and Learning Systems of the Patient Safety and Quality of Care Working Group.

WHO's presentation was enhanced by the contribution of Sir Liam Donaldson, WHO Envoy for Patient Safety, who provided an overview of patient safety and reporting and learning issues.

The launch raised significant interest among the participants.

MINIMAL INFORMATION MODEL FOR PATIENT SAFETY (MIMPS)

- INCIDENT IDENTIFICATION
  - Patient
  - Time
  - Location
  - Agent(s) involved

- Incident type
- Incident outcomes
- Resulting actions
- Reporter

Related Documents

- WHO Draft Guidelines for Adverse Event Reporting and Learning Systems
- ICPS reports & publications

Background

- Working paper - MIM for patient safety
- MIMPS expert review meeting report
- WHO-EU Advancing Reporting & Learning Systems
- International Classification for Patient Safety Reporting & Learning

Ongoing surveys

International consultation, May 2015, Poland

HIS Ideas Bed on MIM project

Mapping of existing systems

Pilot studies in Morocco and India
# MIM for Incident Reporting

<table>
<thead>
<tr>
<th>Information Categories</th>
<th>Definitions</th>
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<tbody>
<tr>
<td>1 Patient/person</td>
<td>the person who is involved directly or indirectly in the safety incident</td>
</tr>
<tr>
<td>2 Time</td>
<td>date and time of day when the incident occurred</td>
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<tr>
<td>3 Location</td>
<td>the physical environment in which a safety incident occurs</td>
</tr>
<tr>
<td>4 Agent(s)involved</td>
<td>product, device, person or any element involved in the incident with the potential to influence it</td>
</tr>
<tr>
<td>5 Incident type</td>
<td>a descriptive term for a category of incidents of a common nature, grouped based on shared, agreed features</td>
</tr>
<tr>
<td>6 Incident outcomes</td>
<td>all impacts upon a patient or an organization totally or partially attributable to an incident</td>
</tr>
<tr>
<td>7 Resulting actions</td>
<td>all actions resulting from an incident</td>
</tr>
<tr>
<td>8 Reporter’s role</td>
<td>the person who collects and writes information about the incident</td>
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WHO Safe Childbirth Checklist (SCC)
- Evaluation of SCC Collaboration sites, and final report
- Finalization of technical content of SCC
- Development of implementation guide
- Launch of the Checklist and the implementation package in Q4 of 2015

WHO Surgical Safety Checklist
- Creation of network for sharing of experiences
  - E-platform being launched by Harvard School of Public Health
Patient Engagement

- Patient safety champions
  - A global network
  - 21 champions in 2005
  - 400 champions today
  - >50 countries involved
- An electronic community
- Workshops
  - In country
  - Regional
  - Global

- Patients for patients communication series
  - Webinars
  - Advocacy
  - Literacy
  - Engagement
    - Patients engagement in medication safety
    - 7-day mother baby mCheck tool
Exploring patient participation in reducing health-care-related safety risks

Source: Exploring patient participation in reducing health-care-related safety risks, WHO Europe 2013

Fig. 1.3. Conceptual model of patient participation in error prevention

HCW-related factors
» Accept new role
» Train in HCW-patient relations
» Support from institution
» Perceived lack of time
» HCW professional category
» Beliefs
» Demographic variables
» Type of problem

Patient-related factors
» Accept new role
» Health literacy
» Legitimacy
» Relevance/stakes
» HCW professional category
» Beliefs
» Demographic variables
» Disease severity

Source: adapted from Longtin et al. (4).

Source: Exploring patient participation in reducing health-care-related safety risks, WHO Europe 2013
Integrated approach with patient safety at the core of high performing health Systems

- Bringing together all factors which can potentially impact the quality and safety of processes
- Engaging the patient as co-producer of own health
PSQ Priorities 2015

- WHO Framework on Patient and Family Engagement
- EU-WHO International Consultation on MIM for Patient Safety Incident Reporting and Learning, 12-13 May, Warsaw, Poland
- Injection Safety Policy and campaign, March 2015
- Launch of Safe Childbirth Checklist, Planned for Oct 2015
- Patient Safety Education and Leadership Guide and High5s
- Global developmental plan and strategic plan for PSQ
  - Strategic framework for cohesive development of PSQ
- Progress on:
  - Global report on safety and quality of service delivery in the context of UHC
  - Evidence base for Safer Primary Care
“If you always do what you always did, you will always get what you always got.”

*Albert Einstein*

THANK YOU