



Progress in quality and patient safety: Are we at a tipping point?

Dr Philip Hassen, ISQua President



Are we at a tipping point? Progress in quality and safety achievements is evident on multiple fronts around the globe. At the recent 27th Annual International Society for Quality in Health Care (ISQua) Conference, held in Paris, there was a passionate desire to advance individual and organizational efforts and articulate a strong vision for the future - to reduce harm to those we serve and improve the systems and processes that our services are built upon to achieve better outcomes.

Over 1 000 abstracts were received and 1 232 people from 72 countries attended the conference. The willingness to share knowledge, work in teams and communicate better with colleagues and patients suggests we may be at a new level of performance in our collective efforts. I never thought I would see such commitment by so many.

The theme of the conference "Quality Outcomes: Achieving Patient Improvement" focused on several topics, including measurement and indicators. Several presenters provided new thinking on how to frame these indicators so we can understand whether we are making real improvements. The fact that many delegates from developing countries attended, with a yearning to understand how best to apply safety and quality measures, and made presentations so others in similar circumstances can benefit, demonstrates the true extent of worldwide participation, awareness and action.

How often in the past have we heard that the harm done was an accepted "recognized complication" about which we could do little? Many now realize we can do better and are applying the skills and knowledge gained from events like ISQua's – taking learnings and insights on how to apply new methods, processes and systems to achieve a level of safety unrealized before.

In response to an identified need, ISQua is developing a knowledge portal to increase system knowledge, capacity and capability to deliver quality care and to improve access to trusted resources and educational activities, including:

- key information and resources in patient safety;
- education and learning resources in safety and quality;
- information for developers building programmes in patient safety;
- innovation, case studies and ideas;
- research and evaluation in patient safety education;
- information and tools for developing/transitional countries with limited access to resources;
- networking and linking with affiliated societies and individuals.

ISQua's mandate to drive quality and safety worldwide through education, research, collaboration and the dissemination of evidence-based practice is marked by strengthening regional groups and collaborating with WHO to advance quality and safety and proliferate a shared vision.

Together, we need to be courageous leaders, intensify our teamwork and communications efforts and remind ourselves, as Sir Liam Donaldson has so well said, that "we must improve ways to maintain each other's competencies as well as improving systems in which we provide care." There is hope for the future. www.isqua.org

Returning to basic issues of quality



Sir Liam Donaldson Chair, WHO Patient Safety

When we in WHO Patient Safety started work on advancing the safety agenda, many international experts asked, "Isn't safety just a new name for improved quality?" While it may be a natural question, this query misses the point that has been ably developed in the literature since those early days around a different "science of safety." Safety has focused on the prevention of error in health-care settings and we now have a body of evidence about what works and what does not in keeping patients safe. At the same time, however, we in the safety field need to return to the basic issues of quality of health care if we are to really move safety and systems strengthening forward.

Contents

- 1 Progress in safety and quality
- 1-2 Returning to basic issues of quality
- 2 2010 ISQua-WHO Scholarships
- 3 Taking safety and quality to Africa
- 4 Hand hygiene improves the safety of patient care
- 5 Can checklists promote new standards of care?
- 6 Measurement and assessment of patient safety in data-poor hospitals
Instilling principles of safety and quality at the outset
- 7 Implementation and evaluation of standardized patient safety solutions
The ICPS: An essential building block to improve patient safety
- 8 WHO Patient Safety news in brief
Recent journal publications of WHO Patient Safety staff
WHO Patient Safety Calendar of events

While any summary of quality will inevitably oversimplify the issue, the vast majority of quality gaps I have seen in travelling and discussing with leaders around the world fall within three main areas.

Slow uptake of evidence

The extraordinary length of time it often takes for documented results of clinical trials to be translated into practice is well documented. Even more surprising is the length of time needed for the dissemination of agreed standards of best practice which are developed well after publication of clinical trial results. Many factors are at play in the slow spread of innovation, from passive factors such as inadequate knowledge dissemination to active factors of resistance to change in clinical practice. We must find ways of surmounting these obstacles.

Variations in standards

Translating evidence into the main stream of care delivery does not mean that a given quality problem is solved. There is a substantial and growing literature on how care in one hospital and one region and one country can vary immensely from care in another hospital, region or country. This variation can be life-threatening. In the United States, for instance, mortality rates associated with pancreatic resections in hospitals which conduct these procedures routinely are three times lower than in hospitals with low volumes of this procedure. This corresponds to over 100 excess deaths per 1000 patients in the latter hospitals - needless deaths.

(Un)patient-centered care

While the infusion of quality methods in health care has improved our knowledge of how to apply best practice, we still treat our patients - with all their individual comorbidities, preferences and issues - one patient at a time. That is the beauty of being a clinician. It is what we used to call the "art" of medicine. However, pressures of time, finance and - in many hospital settings - an increasingly sicker patient population, have meant that our care now relies much more on technology than on teamwork and coordination. Organizations that have mastered the approach to being "patient-centered" have found ways to put the patient at the centre of their quality and safety improvements. Our challenge is in translating these successful examples to others.

How do we achieve high quality?

While the above problems remain challenges in health-care quality and safety, there are important successes on which we can build. In WHO Patient Safety's work, we have recognized a key fact about health-care improvement: supply and demand go hand in hand.

On the supply side of health care, the development of simple, low-cost tools to address the "persistent" risks in health care has been the focus of work to improve hand hygiene and safe surgery globally. On the demand side, by engaging patients in our *Patients for Patient Safety* programme, we have started to understand how to make health care more centered around patients. And by developing sustainable models of change in programmes

such as our African Partnerships for Patient Safety, we work with local partners to spread quality and safety approaches nationally.

Nevertheless, inequity remains the great unaddressed problem in health-care quality and safety. Over the past 10 years, research by WHO and many other organizations has helped to shine some light on the growing problem of inequity in access to health care around the world. The lessons learned across countries, both in the developed and developing world, are important. However, comparatively little effort has been made to examine how quality and safety differ across disadvantaged groups. It is already clear that based on resources, achieving basic standards of care will vary across developed and developing countries. Our next great challenge is, therefore, to ensure that the innovations we develop and the approaches to empowering patients reach every patient, in every hospital, in every country. Every time.

2010 ISQua-WHO Scholarships

2010 was another great year for the ISQua-WHO Conference Scholarship programme. Twelve professionals, including 10 women, from 12 different low and middle income countries across six WHO regions, attended the 2010 ISQua International Conference in Paris, in October. For many professionals, including a grantee of the WHO Patient Safety Research Small Grants programme, their attendance would not have been possible without support from the ISQua-WHO Scholarship programme.

The scholarships enable these 'future leaders' in health-care quality and safety to expand their learning and experience through exposure to international networks and experts in health-care quality while enjoying the rich programme of this excellently run conference. The success of this scholarship programme is a testament to the close collaboration between ISQua and WHO Patient Safety. These are some of the happy faces of those scholarship recipients.



Information about the ISQua-WHO Scholarships for 2011 will be available from February 2011 on the ISQua and WHO Patient Safety web sites.

www.isqua.org

www.who.int/patientsafety/news/isqua_scholarships2010/en/index.html

Taking safety and quality to Africa

African Partnerships for Patient Safety

Improving quality and patient safety are topics which are now receiving increased attention in Africa. Despite the continuing challenge of inequity, overarching patient safety and quality principles can be learned, shared and applied in developing, transitional and developed contexts. In 2009, WHO Patient Safety's programme *African Partnerships for Patient Safety* (APPS) launched a new model of collaboration which focuses on 12 action areas that address basic safety and quality issues for Africa. This framework of priorities is the foundation of all APPS work to improve safety and quality of health care in the region and was endorsed by all 46 countries in the WHO African Region.

The APPS Approach

The APPS approach is built on two-way learning and improvement in quality and patient safety between partnered hospitals in Africa and Europe. At the heart of these partnerships lies the sharing of knowledge and experience between each partner hospital. The programme supports the hospitals to ensure their learning is connected to national systems so others can also learn from the APPS work and sustainability of change is ensured.

The first wave of partnerships saw six partnerships where individuals and organizations have supported APPS to develop the model for patient safety and quality improvement that others can follow. The second wave of partnerships will be launched in the coming months.

"Respect for human life and the common rights of a human being need to be explored in a patient safety context as death is no longer news."

Senior Division Director, WHO African Region, Brazzaville,
February 2009

APPS Tools

The programme has developed a series of tools to support implementation and improvement activities. These include a patient safety situational analysis on which to develop a plan of action, along with a patient safety resource map, a community engagement framework for patient safety, an evaluation framework and a framework to strengthen the patient safety evidence-policy interface.

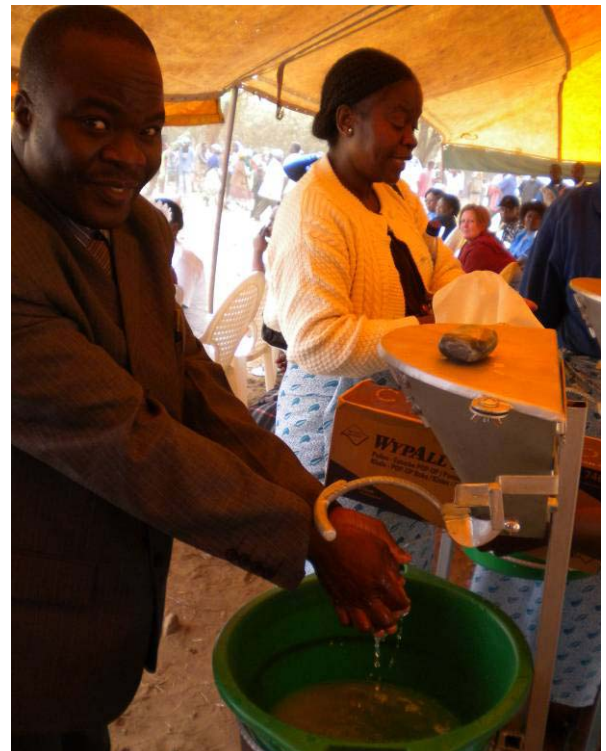
Early Experiences

The critical first step in implementing the programme was to assess the situation in each participating African hospital. Each partnership undertook a rapid patient safety situational analysis. The outcome of this formed the basis of a two-year implementation plan to improve patient safety and quality of services.

Implementation is now under way, following a thorough planning process where programme focal points from each of the hospitals came together in October 2009.

Spread: Ethiopia, Uganda and Malawi

Spreading the knowledge and learning is also an objective of APPS and we are already seeing encouraging results. The Ethiopian Ministry of Health has officially committed to addressing patient safety nationally and is rolling out patient safety activities based on APPS tools in eight other hospitals across the country. Uganda has recognized the APPS focal point for his work at the national level and is looking at ways in which this work can be further integrated into the national health system. In Malawi, directors in the Ministry of Health attended an official launch of APPS at its partner hospital, where they were given a demonstration on the use of alcohol-based hand rub as a way of addressing hand hygiene in the prevention and control of hospital acquired infections.



Hand Washing Techniques as part of official Launch of APPS, Kamuzu Hospital, Lilongwe, Malawi.

The Future

Looking to the future, we need to ask ourselves some fundamental questions: How can safety improvement (particularly reducing health care-associated infections) be a door to broader quality improvements in hospital care? How can communities be engaged to create a "demand" for quality in Africa? And how will improving safety and quality advance broader population health? These questions are not just academic. They focus on some of the most basic rights of human beings to receive safe, effective and quality care. With support from WHO and its Member States, we believe the answers to those questions are within our reach.

www.who.int/patientsafety/implementation/apps/en/index.html

Hand hygiene improves the safety of patient care

Clean Care is Safer Care

Improving the quality and safety of patient care has been at the core of the *Clean Care is Safer Care* programme since it was launched by WHO in 2005. Throughout 2010, the Clean Care is Safer Care team has continued to support Member States in the reduction of health care-associated infections, primarily through improvement in compliance with hand hygiene practices.

Baseline information: Burden of disease related to health care-associated infections

Most countries lack surveillance systems for HCAI and those that do have them struggle with the complexity and lack of uniformity of criteria for diagnosing them. Yet, establishing the magnitude of a problem is one of the initial and essential steps to improving quality. To this end, highlights of the report on the burden of disease related to health care-associated infections (to be published in 2011) were released in May 2010. The report is based on a systematic review and meta-analysis of the available evidence.

These highlights, along with data collected from pilot site testing work conducted by WHO from 2006-2010, were transformed into targeted messages to enhance implementation of the WHO hand hygiene improvement strategy in developing countries and were shared in various conferences and meetings: the joint IFIC & IPCAN conference in South Africa in August 2010, the International Conference on Emerging Infectious Diseases in the USA in July, the Interscience Conference on Antimicrobial Agents and Chemotherapy conference in the USA in September and the international conference of the Hospital Infection Society in the UK in October of this year.

http://www.who.int/gpsc/country_work/burden_hcai/en/index.html.

Culture change: WHO 'My 5 Moments for Hand Hygiene'

Making tasks systematic is also a proven way of achieving quality. The 'My 5 Moments for Hand Hygiene' approach defines the key moments when health-care workers should perform hand hygiene. This evidence-based, field-tested, user-centered approach is designed to be easy to learn, logical and applicable in a wide range of settings. In 2010, the Clean Care team intensified its focus on providing training sessions that promote the practical implementation of the WHO 'My 5 Moments for Hand Hygiene' approach.

These training sessions were aimed at and carried out in conjunction with key stakeholders and partners and have been crucial in cascading hand hygiene improvement methods to a wider audience.

www.who.int/gpsc/5may/background/5moments/en/index.html

Assessing compliance: Global Observation Survey of Hand Hygiene Moment 1

In May 2010, all health-care facilities registered for the WHO **SAVE LIVES: Clean Your Hands** annual campaign were invited to participate in a global survey on or around 5 May, by observing hand hygiene compliance with Moment 1 (before touching a patient). Following collation and analysis of submitted data, results for the overall compliance with Moment 1 by WHO regions and by professions were made available in October 2010. www.who.int/gpsc/5may/news/ps_moment1_results_2010_en.pdf

Number of facilities, recorded opportunities and hand hygiene compliance by WHO region

WHO region	N facilities (%)	N opportunities (%)	Compliance
AMRO	140 (42.8%)	23183 (30.2%)	26%
EURO	99 (30.3%)	22278 (29%)	64%
EMRO	25 (7.6%)	16252 (21.2%)	44%
WPRO	40 (12.2%)	8452 (11%)	61%
SEARO	18 (5.5%)	5091 (6.6%)	54%
AFRO	5 (1.5%)	1547 (2%)	48%

Antimicrobial resistance

World Health Day 2011: Antimicrobial resistance and its global spread

Antimicrobial resistance and its global spread threatens the continued effectiveness of many medicines used today to treat the sick, while at the same time risks jeopardizing important advances being made against major infectious killers. To underline this, WHO has made antimicrobial resistance the theme of *World Health Day 2011*. WHO's annual public awareness campaign will include a special focus on the HIV/AIDS, tuberculosis and malaria pandemics. WHO will call on governments and stakeholders to implement the policies and practices needed to prevent and counter the emergence of highly resistant superbugs, and to also provide appropriate care to those seriously affected by these microbes. WHO Patient Safety is one of several departments within WHO involved in the preparations of World Health Day 2011.

Pledge to improve infection control and deter antibiotic resistance

In an op-ed appearing in the British Medical Journal, ReAct project team members respond to concerns raised by the global spread of bacteria carrying New Delhi metallo- β -lactamase-1 (NDM-1) and resistance to all antibiotics except tigecycline and colistin. Recommendations for action include encouraging hospitals to sign a pledge urging WHO as well as accreditation bodies and other key stakeholders to undertake a process that would improve infection control and deter antibiotic resistance. To join the pledge, please visit <http://www.reactgroup.org/pledge>

Safe Surgery Checklist registrations and adoption to date

Over the last two and a half years, more than 3 900 hospitals spread over more than 122 countries have registered as Safe Surgery Saves Lives Participating Hospitals, signifying their intent to introduce WHO's Surgical Safety Checklist in their operating theatres. Out of these, more than 1800 hospitals have reported they are routinely using the Checklist in at least one operating theatre. In addition, 25 countries have committed resources to introduce the Checklist on a national scale.

Can checklists promote new standards of care?

Safe Surgery Saves Lives

Since the release of the WHO Surgical Safety Checklist by WHO Patient Safety's *Safe Surgery Saves Lives* initiative in June 2008, the concept of the checklist has been the subject of much interest. Can a checklist be the link between knowledge and practice at the bedside? Can it promote new standards of care? Discussions during a WHO plenary session at the ISQua 2010 Conference in Paris earlier this month, addressed these questions, among others.

Standardisation makes a difference: the Surgical Safety Checklist

A checklist is a quality improvement tool to ensure consistency of practice to reduce provider variation. It standardizes care processes, aids memory of clinicians and is a tool to improve communication and teamwork.

Hospitals that have started using the Surgical Safety Checklist have begun to collect local evidence that the Checklist makes a difference in surgical care. Recently, Stanford University presented their findings at the 2010 American College of Surgeons Annual Clinical Congress held in Washington D.C. Researchers at Stanford found that the observed/expected mortality ratio declined from .88 in quarter one to .80 in quarter two with the use of a modified version of the WHO Surgical Safety Checklist.

Moreover, they found that the use of the Checklist increased the frequency in which staff reported "Patient Safety Never Events" while the number of Patient Safety Never Events that were related to errors or complications decreased from 35.2% to 24.3%. Overall, the Checklist has not only impacted outcomes, but it has also improved communication among the surgical team, and thus quality of care.¹

1. Abstract, American College of Surgeons Annual Clinical Congress. Oct 2010

www.who.int/patientsafety/safesurgery/en/index.html

Expanding the concept of the Surgical Safety Checklist to other care areas

Following in the footsteps of the WHO Surgical Safety Checklist, WHO is also developing a *Safe Childbirth Checklist*. This is a simple tool that frontline care-givers can use to ensure that essential care practices are performed. WHO is currently doing a single centre trial of this checklist in Belgaum, India.

A *Trauma Care Checklist* has also been developed in response to data indicating that up to 10% of preventable deaths caused by human and system errors occur in trauma care. The Trauma Care Checklist is currently being pilot-tested in 13 hospitals around the world.

WHO embarked on the development of new checklists with the understanding that checklists are not the solution to all problems and that they need to be adapted to local context to be adopted and implemented. The implementation of a checklist alone is not enough but when embedded in a quality improvement process, a checklist is an excellent tool to assist improvement.

Surgical Safety Checklist

World Health Organization Patient Safety

Before induction of anaesthesia (with at least nurse and anaesthetist)

- Has the patient confirmed his/her identity, site, procedure, and consent?
 - Yes
 - No
- Is the site marked?
 - Yes
 - No
- Is the anaesthesia machine and medication check complete?
 - Yes
 - No
- Is the pulse oximeter on the patient and functioning?
 - Yes
 - No
- Does the patient have a:
 - Known allergy?
 - Yes
 - No
 - Difficult airway or aspiration risk?
 - Yes
 - No
 - Yes, and equipment/insurance available
 - Risk of >500ml blood loss (Red flag in children)?
 - Yes
 - No
 - Yes, and two 10cm central access and fluids placed

Before skin incision (with nurse, anaesthetist and surgeon)

- Confirm all team members have introduced themselves by name and role.
 - Yes
 - No
- Confirm the patient's name, procedure, and where the incision will be made.
 - Yes
 - No
- Has antibiotic prophylaxis been given within the last 60 minutes?
 - Yes
 - No
 - Not applicable
- Anticipated Critical Events
 - To Surgeon:
 - What are the critical or non-routine steps?
 - How long will the case take?
 - What is the anticipated blood loss?
 - To Anaesthetist:
 - Are there any patient specific concerns?
 - To Nursing Team:
 - Has sterility (including indicator results) been confirmed?
 - Are there equipment issues or any concerns?
 - Is essential imaging displayed?
 - Yes
 - No
 - Not applicable

Before patient leaves operating room (with nurse, anaesthetist and surgeon)

Nurse Verbally Confirms:

- The name of the procedure
- Completion of instrument, sponge and needle counts
- Specimen labelling (and specimen labels attached, including patient name)
- Whether there are any equipment problems to be addressed

To Surgeon, Anaesthetist and Nurse:

- What are the key concerns for recovery and management of this patient?

This checklist is not intended to be comprehensive. Additions and modifications to fit local practice are encouraged. August 1, 2009 © WHO, 2009

The Surgical Safety Checklist as a stepping stone

In addition to spreading use of the WHO Surgical Safety Checklist, the Safe Surgery Saves Lives Initiative is also undertaking a project to improve the linked area of anesthesia safety around the world. When the WHO Surgical Safety Checklist was tested in the eight center international pilot study, its use was limited to those hospitals that had access to pulse oximetry. Experts quickly recognized that in order for the Checklist to be effective in all hospitals, it would also need to be introduced to environments that do not have access to adequate pulse oximetry technology.

This anesthesia safety project, therefore, addresses the issue by studying the effect that the introduction of the WHO Surgical Safety Checklist and pulse oximetry, together with a comprehensive anesthesia training module, has in operating theatres where pulse oximetry was not previously available. The study has already kicked off in two hospitals (in Moldova and Zambia) and will shortly start in a third country. The use of the WHO Surgical Safety Checklist in conjunction with the introduction of pulse oximetry will thus be studied in approximately 10 000 surgical cases during the course of this study.

www.who.int/patientsafety/safesurgery/pulse_oximetry/en/index.html

Measurement and assessment of patient safety in data-poor hospitals

Research and Knowledge Management

Patient safety assessment is essential to design and monitor activities aimed at improving the quality and safety of patient care. Several academic groups, patient safety agencies and quality agencies have proposed various patient safety indicators to measure the status of patient safety. However, in many health-care facilities, such assessment is hampered by the scarce availability of data, or by limited resources and infrastructure for the collection of data.

A Template for Safety Assessment

To address this issue, the WHO Patient Safety *Research and Knowledge Management* team, assisted by an international expert task-force, is working to identify a series of measures of hospital patient safety status that could be obtained even in settings lacking robust information systems. Data-poor hospitals, as they are known, are those that do not routinely collect information about characteristics of the patient and/or of the process of care and/or where the data sources are not accessible and/or reliable. Located anywhere in the world, these hospitals are more often found in developing and transitional countries. The goal of this exercise is therefore to develop a framework for patient safety improvement which is of relevance to developing and transitional countries, by providing a template for patient safety assessment that is applicable in data-poor hospitals.

The WHO expert task-force recognized that assessment for patient safety improvement needs to focus on structural, process-oriented and outcome-based elements of the hospital environment. While it is recognized that these determinant factors may vary over time and across health-care systems and socioeconomic contexts, it is also felt that a high level description of both the patient safety outcome areas as well as the key process and structural determinant factors may be useful as a framework for indicator development for a wider constituency.

Based on these principles, the WHO expert task-force established the following objectives:

- to identify and prioritize the most relevant types of harmful incidents that represent a risk of harm to patients in hospital settings and in a broad range of health-care contexts;
- to identify and prioritize high-level structural and process factors that are related to, or determine, the occurrence of patient harm in hospital settings;
- to create a database of candidate measures that are precursors to harmful incidents and to identify high-level structural and process factors in hospital settings.

At the end of this process, WHO will provide data-poor hospitals with a set of simple measurements that will allow them to assess the patient safety situation in their hospitals

and design and implement strategies for improvement. www.who.int/patientsafety/research/methods_measures/indicators_dph/en/index.html

First Small Grant Presentations at ISQua

Also contributing to the work on measures and measurements in developing countries is research conducted in low-resource and transitional countries funded through the *Small Grants* Programme of WHO Patient Safety Research and Knowledge Management. Dr David Bates, External Lead for WHO Patient Safety Research and Knowledge Management, along with two grantees, Ms Gertrude Sika Avortri from Ghana, and Dr Richard Inga from Peru, were among speakers at the ISQua 2010 Conference session "*Improving health outcomes in low-income countries*".

Ms Sika Avortri presented the results of her research on "*Patient safety culture: Perceptions and reporting behaviours among health staff in Ghana*". Her presentation gave insight into health systems in Ghana and opportunities where good quality local research can contribute to health-care improvement. Dr Inga presented his research work on the "*Impact of the WHO's Surgical Safety Checklist in reducing adverse effects in surgical centres in Peru*". He emphasized that the conduct of his research not only benefited hospital staff in terms of training opportunities, but also helped raise awareness of patient safety among hospital authorities and health-care professionals. www.who.int/patientsafety/research/grants/en/index.html

Instilling principles of safety and quality at the outset: The Patient Safety Curriculum Guide

At two sessions on the *WHO Patient Safety Curriculum Guide*, held during ISQua 2010 Conference, participants heard about WHO actions to support the education and training of students in patient safety. Discussions were also held around the contribution of experts from around the world and international professional associations towards updating the 2009 WHO Curriculum Guide for Medical Schools to become the *Multi-professional Edition* in 2011.

The multi-professional edition aims to inform, support and assist the inclusion of patient safety in the curricula of health professionals in training and is being developed by WHO Patient Safety in partnership with regional experts and international professional associations, such as the International Confederation of Midwives, the International Council of Nurses, the International Pharmaceutical Federation, the International Pharmaceutical Students Federation, the World Dental Federation and the World Medical Association.

The ISQua sessions were preceded by a one-day meeting of experts from around the world, and the international professional associations. The experts discussed the updated multi-professional edition of the curriculum guide and achieved a consensus on the evidence-based content suitable for use in the training of all health professionals. The meeting also discussed the processes of dissemination and evaluation of the updated version of the curriculum guide. www.who.int/patientsafety/education/curriculum/en/index.html

High 5s: Implementation and evaluation of standardized patient safety solutions

A WHO Patient Safety initiative, *High 5s: Action on Patient Safety* is a multi-country, multi-agency collaboration aiming to facilitate the implementation and evaluation of standardized patient safety solutions. The *High 5s* name derives from the initiative's original intent to significantly reduce the frequency of five challenging patient safety problems in five countries over five years. To date, three protocols have been developed:

- medication reconciliation
- correct site surgery
- control of concentrated injectables.

The latest developments and progress achieved by High 5s were presented during a lunchtime session at the recent ISQua Conference. Three protocols are now being implemented in about 110 hospitals in the participating countries: Australia, France, Germany, the Netherlands, Singapore, the UK and USA. Data collection tools have been developed for evaluating the implementation and performance of protocols, as well as event analysis (root cause analysis). Hospital data will be collected over a period of 18-24 months and will generate learning that will permit the refinement of the protocols, as well as assessing the success of implementing standardized approaches across multiple countries and cultures.

Following the ISQua 2010 Conference, the High 5s Steering Group met at the headquarters of Haute Autorité de Santé in Paris, to discuss global and national progress achieved by country lead technical agencies, as implementation of the protocols is well under way. The group discussed the project's intermediate objectives in terms of dissemination of knowledge and lessons learned following the implementation of protocols, and the participation of new countries in the collaboration. Issues related to the adaptation of protocols to local settings, improved communication among steering group members and the setting up of a publications processes for publishing papers arising from the implementation of the protocols, were discussed.

<http://www.who.int/patientsafety/implementation/solutions/high5s/en/index.html>

An essential building block to improve patient safety

The International Classification for Patient Safety

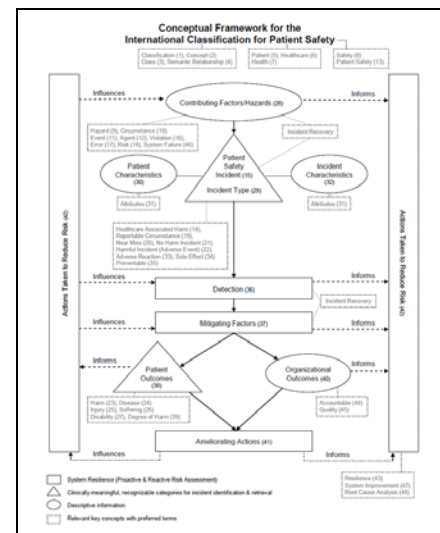
Before we can identify solutions to quality and safety problems, we need to have a good understanding of concepts and terminology related to them. Although this sounds intuitively simple, the reality is that arriving at these building blocks is a lengthy and laborious process, but a necessary one.

The ICPS is a framework for:

- Deconstructing incidents
- Eliciting and capturing information
- Learning from the occurrence of incidents and the actions taken
- Storage analysis and strategy development
- Compendium of evidence-based actions
- Developing solutions to prevent incidents or mitigate the harm produced.

WHO Patient Safety initiated work on a standardized classification for key patient safety concepts that will help elicit, capture and analyse factors relevant to patient safety in a manner conducive to learning and system improvement. The International Classification for Patient Safety (ICPS) aims to define, harmonize and group such concepts into an internally agreed classification that will be adaptable and consistent across the entire spectrum of health care and across cultures and languages.

Over the past few years, a group of experts in the fields of patient safety, classification theory and development, health informatics, consumer advocacy, law and medicine have developed, agreed on and published a conceptual framework for the International Classification for Patient Safety (ICPS). This framework, representing the essential concepts underpinning the occurrence and consequences of harmful incidents with over 50 key terms, is undergoing peer review and was presented by the WHO Patient Safety external expert collaborator on ICPS, Prof Bill Runciman, during a plenary session at the 2010 ISQua Conference.



A web-based collaborative authoring tool (iCAT) is being developed and ontology development is proceeding to pave the way for developments such as automated reading and translation into different languages. The development of the full ICPS is foreseen to run from 2010 until 2014, when it will be submitted for approval to WHO's World Health Assembly. The ultimate challenge will be engaging the health-care community to adopt it with the objective of facilitating learning and changing their practices.

www.who.int/patientsafety/implementation/taxonomy/en/index.html

WHO Patient Safety news in brief

Patients for Patient Safety

PFPS is creating a patient held safety tool that will increase the safety of mothers and their newborn babies during the first seven days after birth, considered a high-risk period. This tool is being developed by patients for patients and will list safety checks of common danger signs for mothers and their babies. It will be simple and easy to use globally in settings of varying economic profile and literacy.

http://www.who.int/patientsafety/patients_for_patient/en/

Sir Liam Donaldson in the USA and Canada

In September 2010, Sir Liam Donaldson's presentation as part of Johns' Hopkins Grand Rounds series was very well received in Baltimore, Maryland. A subsequent presentation to USAID and US HHS on safety and quality and their support for health systems strengthening was a stepping stone for ongoing discussions between these potential partners.

Additional meetings in the US enabled WHO Patient Safety to explore international applications of the University of Illinois Chicago's award winning "open disclosure" approach to patient safety and to pursue partnership agreements with AHRQ, while meetings in Canada yielded agreements on future collaboration between the Canadian Patient Safety Institute (CPSI) and WHO Patient Safety.

Renewal of the WHO Patient Safety Strategy

What are the challenges for improving patient safety globally in the next five years and what role should WHO Patient Safety play within that? What are the gaps and issues that we still face today? These and other questions were discussed and debated from various perspectives by an international panel of patient safety experts during the ISQua 2010 Conference (photo below).



Input from this session will be included in the next WHO Patient Safety Strategy, currently being developed. The strategy is scheduled to be launched mid-2011.

Questions or comments?

Send us an e-mail: patientsafety@who.int

Recent journal publications of WHO Patient Safety staff

Developing safe effective and accessible technologies: WHO Editorial. *Quality and Safety in Health Care*. Aug 2010. vol 19 (supp2). Yang GZ, Kelley E, Darzi A.

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Conferences and events for WHO Patient Safety staff

Below are some events with WHO Patient Safety staff participation.

4 November - APPS

Shaping the Future: Growth, Impact and Innovation Nottingham, UK
<http://www.thet.org/health-links-conference-2010/>

16-19 November - WHO Patient Safety

Global Symposium on Health Systems Research Montreux, Switzerland <http://www.hsr-symposium.org/>

19 November - Safe Surgery Saves Lives

Conference on Risk Reduction in Surgery
Bertrange, Luxembourg.
http://www.esqh.net/Members/noel/agenda/event20100115124348/vi-ew?portal_status_title=AGENDA



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