

WHO Global Consultation

Setting Priorities for Global Patient Safety

Executive Summary

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Florence, Italy

Organized by:



In collaboration with:



Introduction

The quality and safety of health care are areas that are often dealt with outside of the public view. Patients assume that their medical care is of the highest calibre, and trust health care services to take care of them when they are in need. However, there are an indeterminate number of risks and errors occurring every day in health care around the world that can lead to harm, disability and even death. The global toll of health care associated harm is hugely significant.

In September 2016, WHO Patient Safety and Quality Improvement unit organized the first Global Consultation “Setting Priorities for Global Patient Safety” in collaboration with the Centre for Clinical Risk Management and Patient Safety, Florence, Italy, a newly designated WHO Collaborating Centre in Human Factors and Communication for the Delivery of Safe and Quality care. The aim of the consultation was to cultivate a global expert think tank to deliberate and identify key challenges, new directions and hot topics in an effort to prioritize future actions for global patient safety over the next 5-10 years.

The event was designed and chaired by Sir Liam Donaldson, WHO Envoy on Patient Safety. Around 140 participants from 30 countries attended, which included international experts, academic leaders, senior officials, policy makers, national patient safety focal points and programme leads from ministries of health, representatives from international and inter-governmental organizations, leaders of healthcare organizations, researchers in safety, implementation sciences and technology, experts from aviation and bio-robotics fields and leaders from accreditation and professional organizations. Specific themes highlighted during the global consultation included: education and training, leadership, interdisciplinary teamwork and communication, implementation science methods, patient engagement, research, total systems and integrated approaches, sharing of success stories, medication safety, diagnostic errors, health care associated infections, and organizational transparency to learn from mistakes and foster a safety culture.

This was an event of immense strategic importance for envisioning the future and strategic directions for global patient safety, providing a renewed sense of momentum for improving global patient safety. The event fostered a new thought leadership and direction on a global level from leading experts and represented the beginnings of a “renaissance in patient safety”. The consultation provided an important opportunity to share best practices and experiences, learn effective strategies in the implementation of evidence-based interventions and identify priorities for future action to scale up implementation.

Overall the event was hailed as a watershed for patient safety, advancing global thinking, informing leaders, setting standards and helping set a new strategic direction for WHO and its global partners. The consultation was highly effective in bringing together key international experts and various representatives to identify major constraints in patient safety, inform new directions and priorities, guide WHO’s global actions in the areas of patient safety, and further strengthen the commitment of stakeholders at institutional, national, regional and global levels, as part of improving access to quality health care and advancing towards universal health coverage.

Synthesis of priorities for global patient safety

At the global level, participants emphasized the need to establish comprehensive priorities to help guide countries in setting their own. Importantly, refining an internationally agreed upon definition of 'patient safety', 'error' and 'harm' is required. Participants suggested the need to embed the concept of 'patient safety' into wider quality improvement strategies. Contained in this is the idea of 'risk prediction' to help make proactive, rather than retrospective, actions in order to mitigate the chance of error or harm from occurring.

The increased global focus on "whole systems" approaches have been strongly welcomed, but still more emphasis is needed on holistic approaches to health care, integration and coordination and primary health care. Supporting and cooperating with low-income contexts is crucial for future directions. Standardized tools to be implemented worldwide can certainly be helpful, but experts urged for 'individualized' solutions to be developed that consider local socio-cultural factors.

Creating a sense of urgency among policy-makers and politicians by raising awareness can help kick-start the much needed culture shift towards safety and learning. Cross-fertilizing techniques from business fields for devising persuasion tactics, compiling hard-hitting evidence, and developing concrete and practical guidance, could be capitalized on to gain buy-in from influential stakeholders. Such guidance could include recommendations on how to achieve 'a culture of safety', exploring concepts such as transparency, accountability, hierarchy, trust, reporting and learning, open disclosure and other key components. This should include a package of 'Best practices' that have been proven to make a positive impact on patient outcomes and experiences.

Stressing the economic benefits of improving patient safety is an important advocacy tool to demonstrate costs could be saved through implementing patient safety policies. Guidance should include assessment manuals to analyse current levels of patient harm, as well as key local barriers for implementing improvements. This assessment can recognize the differences between institutions, as well as within institutions. The guidance should 'speak the language' of the stakeholder in which it is intended for, so methods can be devised and shared to appropriately engage the intended audience.

The importance of incorporating concepts of safety into pre-graduation curricula, as well as into ongoing training for certified health professionals, is well-known. However, methods on assessing the extent to which professionals have learned, or become more competent, need to be devised and circulated widely. At the global level, a certified patient safety course/s could be developed, or courses that are already available needs to be promoted or adapted, depending on the local circumstances. As one participant highlighted, most health workers already have a huge work load and curricula, so implementing new tools or checks can increase workload and lower motivation. Only interventions which are proven to be successful in conjunction with each other should be promoted. Methods to engage staff and understand barriers to safety improvements can be explored to help empower them.

Social sciences, such as human factors approaches and implementation science can help determine and innovate new strategies for more effective solutions. The social determinants of safety and quality should be explored, as well as new methods that consider cultural, social and behavioural factors.

Patient safety lens is an important one within the global strategic objective of achieving universal health coverage. The concept of 'equity' and 'quality' is important for patient safety, as all patients and families should be able to trust their health services to not just provide health care, but health care that is effective, efficient and safe.

The following ideas and recommendations were expressed by participants on different areas:

Leadership, accountability and political commitment

Building leadership competency through education to promote a better understanding of patient safety and the methods, measures and tools to tackle patient harm can not only improve safety but also accountability. This includes leaders at all different levels of the health care system like policy-makers, politicians, hospital managers (or chief executive and operating officers) and middle-management personnel. Leadership is vital for promoting transparency, safety culture, and obtaining political commitment from influential stakeholders. Such political commitment can help translate safety into national level policies. This will require the equipping leaders with data on the cost, benefits and efficacy of patient safety improvement strategies. Consistent messaging about the intolerance of harm and unsafe care is one suggested means to help leaders.

Surgical safety

Patient safety in surgery has had success with the introduction of the surgical checklist. However, the next steps need to be focused around proper implementation of the checklist, addressing the culture of blame within the specialty and using more well-rounded means of assessing surgical skills and capability, including technology and simulation.

Diagnostic safety

While diagnostic errors are both difficult to measure and evaluate, it is none the less hugely important to address incorrect diagnosis. Institutions need to accurately record and measure their diagnostic errors, have a no blame system of reporting and to then disseminate that data to all staff in an anonymous and constructive manner. Data can be shared amongst institutions in order to increase knowledge and share experiences to facilitate ongoing learning.

Health care associated infections and anti-microbial resistance

Infection remains an area that requires attention, particularly in low- and middle-income countries. There are many contexts in which policies or protocols on reducing health care associated infections do not exist or are inadequately enforced. Strategies on managing the pathways of infection and anti-microbial resistance and how various people can contribute needs to be devised, implemented, and monitored, especially in settings where none exist. Addressing sepsis and surgical site infections as major issues will require attention in the hospital settings with emphasis on correct pathways of diagnosis and treatment of infections, in primary care settings through the

education of health professionals and the public, and through raising awareness of the need for new treatments with increasing antimicrobial resistance.

Human factors and implementation science

The usefulness and applicability of the social sciences in improvement methods was mentioned repeatedly. Guidance needs to be provided that utilizes implementation science for change management and the scaling up of effective strategies. This might include management practices, encouragement of compliance and behavioural change methods for implementing changes in quality and safety. The focus here is better understanding of the reality on ground, and where qualitative methods can be used to tackle weaknesses and build on strengths. It was suggested to use accreditation, advisory boards or competency exams to assess modes and rates of compliance.

Education and training

Experts recommended the adoption of a “safety education before graduation” programme, which should include the minimal safety knowledge and strategies to make a difference. Experts recommended that the following topics should be incorporated into medical curricula: human factors, culture of learning from error and successes, choosing and using safe technology, safety monitoring, value of examples and stories, patient engagement, workforce engagement and the role and availability of external, local safety organizations. Critically, education about patient safety needs to be holistic in nature and address pre-vocational students, current healthcare professionals and patients and their families.

Within ongoing medical training programmes for certified professionals, improving inter-professional communication and teamwork was strongly encouraged. By educating each group with reference to the others there can be a more well-rounded learning experience which will translate into a more unified approach to patient safety from all parties. Conducting the ongoing assessment and testing to evaluate the competency of professionals after training should also be integrated. Open access, online, widely-applicable, easy-to-use courses to train people at all levels in their own language could help tackle knowledge gaps in low-income contexts.

Reporting and learning

Apart from the need for the robust, patient-centred reporting and learning systems to be implemented everywhere; key recommendations for reporting and learning were made. Firstly, the ‘learning’ component of reporting needs to be stressed for preventing the reoccurrence of preventable adverse events. Experts recommended the exploration of new measures and methods to prevent reoccurrence, such as the “Success Case Analysis” method that explores how success happens and how improvements can be spread. Secondly, the ‘blame’ and ‘shame’ culture needs to be exiled. It was suggested that ‘near misses’ are easier to talk about than adverse events which resulted in patient harm, so this could be an area to begin the transition towards a safety and learning culture. Thirdly, reporting systems for patients are recommended to gain useful insights from the perspectives of patients and their families. A number of patients who have suffered harm were present at the meeting who advocated for the need to let patients and families to feel ‘listened to’ after an incident.

Engaging the media

One suggestion to address the negative publicity of patient harm is to engage media effectively, which could involve developing guidance for health care leaders and officers in charge of media relations, to work with journalists for refining public messaging. The idea that journalists can twist words to make claims that are accusatory, blaming, victimising, inappropriate, factually incorrect and fear-mongering, is not unheard of in many countries. Cooperating more with the media to get the right messages is crucial to ensure the trust in health systems remain and for informing populations with correct information. This can be achieved if high-quality research sources are developed and disseminated.

Learning organizations

Because health care organizations deals with people and their health, it is vital that they are learning organizations, and continue to better the systems and processes that form the backbone of practice and patient care in their facilities. The main areas that participants suggested for organizational learning were through health care leaders championing change, listening to workers, patients and their families and being critical of systems that do not deliver what they are intended to, and being prepared to change them so that they do.

Aviation and high reliability organizations

Medicine needs to learn from the successes of the aviation industry and other high reliability organizations. The experts suggest that the way to do this is by taking the themes of these industries and adapting them to health care. A systems-wide approach with a focus on preventing harm before it happens, learning from errors and having sufficient training in simulations of major events are useful tactics, along with sufficient buy-in from champions of patient safety to lead from the front lines of health care.

Improvement methods, tools and checklists

Equipping health care professionals with tools to help ensure safety at the sharp end can be useful but also overwhelming. It was proposed that many professionals feel extremely busy and in some cases, uniformed about how to use the tool correctly and meaningfully. It is important to develop guidance for them to understand the bigger picture, in other words, how using this tool correctly contributes to wider institutional, regional or even national goals.

Technology and simulation

Technology is growing at an unprecedented rate, and the health care industry could benefit from taking full advantage. Appropriate evaluation of technology needs to be done, along with the education of both health care professionals and patients in order to fully utilize it. The main areas where technology can improve patient safety are: system checking, particularly with dispensing of medications, simulation and training, and IT systems to deal with both day-to-day patient information and administration but also for education and reporting.

Barriers to patient safety

The key barriers that the participants of the consultation highlighted included:

- the need to address the blame culture in health care towards patient safety;
- having systems that are inflexible and do not work well;
- lack of investment in technology;
- not fully utilizing reporting systems and then disseminating that information for education;
- not focusing on the patient perspective within all areas of health care decision making;
- lack of ongoing evaluation and education in health care at an expert level; and
- the perceived cost barriers to investing in prevention of patient incidents and errors.

Targeting resource-constrained contexts

It is certain that efforts need to be concerted towards tackling patient harm and safety errors in low income settings where strategies, policies or even education may not exist. A suggested priority would be to encourage and provide guidance on adapting WHO materials in high-priority settings. Another idea was to support development of an online networks and a web-based resource platform to feature news updates, alerts, essential resources, literature, tools, and best practices that are relevant for low- and middle-income countries.

Sharing knowledge, developing best practices and disseminating learning

This topic was certainly a popular one during the consultation, particularly around the promotion of online networks and web platforms for knowledge sharing as a low-cost solution to knowledge exchange. Sharing “success stories” was a prominent theme, summed up in the following quote:

“Collect success stories and effective evidence and apply them. We do not have enough success stories. Many of our current patient and staff stories are tragic, compelling, and — we think — ultimately distracting from the long-term cause of safety. While we should seek out, hear and continue to collect incident-based stories, we also need a proactive approach to find and nurture success stories. We already know we need to change our culture, we now need to prioritise changing it”.

Attention was strongly placed on how to find the ‘common denominator’ of the successful 90% of interventions, and making these denominators well-known to researchers, academics and relevant individuals when devising new methods. A platform for enabling sharing of knowledge-based resources for global learning about mechanisms and ideas for improvement, that embrace learning about the content and execution as well as guidance on adaptation to local contexts; could include: an international consensus exercise (e.g. CHINRI method) to determine the priorities by income setting, which involves all stakeholders including patients.

World Patient Safety Day

Establishment of an annual day to raise global awareness on patient safety issues and engage key stakeholders in the development and implementation of patient safety strategies, through a global campaign for a World Patient Safety Day, was suggested to be observed annually, in cooperation with all key partners.

