About Patients for Patient Safety

The World Health Organization describes Patient Safety as “a fundamental principle of health care. Every point in the process of care-giving contains a certain degree of inherent risk. Adverse events may result from problems in practice, products, procedures or systems. Patient safety improvements demand a complex system-wide effort, involving a wide range of actions in performance improvement, environmental safety and risk management, including infection control, safe use of medicines, equipment safety, safe clinical practice and safe environment of care”.

In October 2004, the World Health Organization (WHO) officially launched the World Alliance for Patient Safety (World Alliance) to raise awareness and political commitment to improve the safety of care and to facilitate the development of patient safety policy and practice in all WHO member states. Patients for Patient Safety was established by WHO shortly thereafter to ensure that the experience, perspective, and wisdom of health consumers in both developing and developed countries is infused in the work of the World Alliance. In addition, Patients for Patient Safety was developed to be a collective global voice for health consumers with patient safety concerns, who are forward looking and interested in partnering with each other as well as with providers and policymakers to make a difference.

Australian Workshop and the Perth Declaration

The Inaugural Australian Patients for Patient Safety Workshop, held over 3 days in Perth from July 7 -9, 2009, brought together a group of 40 health consumers, many of whom had experienced medical error or health system failure, health providers and health policy makers from around Australia. Participants were selected for their efforts as change agents who have worked proactively to improve the safety of health care in Australia and their desire to further improve safety in health care, in partnership. Participants came together to build trust, functional working relationships grounded in mutual respect and appreciation of what each brought to the field of patient safety and to form strategies and action plans for improving patient safety in Australia. The core of those strategies and action plans is the Perth Declaration for Patient Safety.

Crafted from experience, insight and vision the Perth Declaration for Patient Safety is a foundation document for patient safety in Australia. The Perth Declaration and the Inaugural Australian Patients for Patient Safety Workshop, build on a series of workshops held across the world which began with the launch of the Patients for Patient Safety Program of the WHO World Alliance for Patient Safety in November 2005 in London. The London Workshop included representatives from 21 countries who applied to attend because of their interest in building partnership between providers, consumers and policymakers to advance patient safety. As one of their products, that group produced what has become known as the London Declaration, which is a Pledge of Partnership. The London Declaration is a core document of the WHO World Alliance for Patient Safety. The Perth Declaration for Patient Safety continues and aligns with this Pledge of Partnership as an Australian community of committed people who seek to ensure future health care users are not harmed.

The Inaugural Australian Patients for Patient Safety Workshop was a collaboration between the World Health Organization’s World Alliance for Patient Safety, Patients for Patient Safety (London); Global Patients for Patient Safety Champion - Stephanie Newell (Australia); Partnerships 4 Patient Safety, Mr Martin Hatlie (Chicago); Health Consumers Council WA; Western Australian Department of Health – Office of Safety and Quality and Curtin University of Technology (WA) – Faculty of Health Sciences.

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1 www.who.int/patientsafety
We, the participants of the inaugural Australian Patients for Patient Safety Workshop, convened in July 2009 to share profound health care experiences in our lives and to take forward our call for action to improve patient safety in Australia.

We are patients, family members, carers and health professionals - people from all walks of life. Each one of us is a testament to the personal experience of unintended harm in health care and its continuing impact. Much of that harm was preventable.

We declare

ί Policies and protocols alone have not made us safer. This problem is systemic, widespread and deep-rooted. The fact that any person or family could one day experience needless devastating harm within the health care system is unacceptable

ί Action must be taken now across all aspects and all levels of health care to prevent more harm occurring to others

ί Our trusted health care workers and managers must recognise that we, your patients and our families, are an invaluable asset and resource for improving patient safety. We offer our stories and experiences. Seek to learn from our hard-won wisdom and partner with us to make lasting change

ί We are the owners and funders of our health care systems and have collective responsibility for them. We ask everyone in the community, including health care providers, administrators and the Government, to join us in making the right to safe health care a priority for all people, especially those who are currently disadvantaged

ί Care has no borders, neither does harm. The journey through all care settings must be better coordinated as too many lives have been lost or grievously harmed on this journey

ί We need to receive care that conforms to the best evidence and practice. Safe practice must be supported by the reporting of and learning from patient safety incidents, education, innovative solutions and information

ί Many barriers exist for Aboriginal and Torres Strait Islander people which limit access to safe health care. Interpreter services, effective transport, communication and accommodation are all integral elements of patient safety

ί Patients know their own bodies better than anybody else. It makes sense to include patients in decisions about their care and treatment. Patients must always be told the options available, the expected outcome of each option including risks and complications, and the likelihood of each outcome occurring

ί Patient safety is a basic human right. When harmed, people have the right to timely apology, explanation, redress and other remedies meaningful to them

ί In accepting that all humans err, we nevertheless dedicate ourselves to ensuring that effective systems are in place to

- Track and learn from health care errors, adverse events and near misses
- Minimise the impact of errors on all involved, including the care provider
- Make changes to prevent the same errors happening again

ί Current reporting arrangements have failed to deliver safe health care for patients. We accept that everyone, including patients, their families and clinicians, needs to safely report patient safety issues and problems. We therefore demand the application of improved patient safety legislation, including sanctions, which enables good clinical practice and provides real safety

ί We cannot stay silent any longer, waiting and watching as more people are harmed in healthcare. As Australians, we own this problem and will work together with actions that go beyond words. To progress this call for action to improve patient safety, we expect partnership at all stages and at every level of the Australian health care system

This Declaration is our kindling. We, the participants of the inaugural Australian Patients for Patient Safety Workshop, will use it to ignite the flame of change to advance patient safety for everyone.

This is our promise.

Perth, AUSTRALIA
August 5, 2009