World Patient Safety Day 2024

WHO Global Consultation

Improving diagnostic safety and implementing the Global Patient Safety Action Plan 2021-2030

10th – 12th September 2024
Geneva, Switzerland

World Health Organization

World Patient Safety Day 17 September 2024

Address by the Assistant Director General

Dr Bruce AYLWARD
Assistant Director-General
WHO Headquarters
Geneva, Switzerland

World Health Organization

World Patient Safety Day 17 September 2024

Session 3
Charting the path to diagnostic excellence

Chairperson
Sir Liam DONALDSON
WHO Envoy for Patient Safety
WHO headquarters
Switzerland

Co-chairperson
Helen HASKELL
President, Mothers Against Medical Error USA

World Health Organization

World Patient Safety Day 17 September 2024

Recap of Day 1

Dr Irina PAPIEVA
Technical Officer/Lead a. i.
Patient Safety Flagship,
Integrated Health Services
WHO Headquarters
Switzerland

World Health Organization

World Patient Safety Day 17 September 2024

Unlocking the concept of diagnostic safety

- Complex, cross-cutting concept that is fundamental to the very core of health care – yet often an overlooked aspect of patient safety
- Correct, timely (missed or delayed) diagnosis, and properly communicated diagnosis is the first step to appropriate interventions and effective treatment.
- It's about people, but also technology: the interface between human beings and technology (balance, reliability, trust) and the role of AI
- Main causes: systemic challenges (access to care, diagnostics, competent workforce), communication issues, cognitive biases
- Every step in the diagnostic process is vulnerable to errors

What does diagnostic safety mean to us

- It concerns everybody and multiple stakeholders should be involved in improving diagnostic safety
- Different perspectives – one truth:
  - Patients: listening and unfolding experiences, sharing data
  - Health workers: competencies, teamwork and communication
  - Organizational leaders: enabling environment (including transparency and safety culture), efficient and effective processes
  - Policy makers: design of the system, resources, prioritization
  - WHO: health system strengthening lens while maintaining the focus areas (TB, ageing, health workforce, diagnostics)

State of Science

- Diagnostic errors are a major source of preventable patient harm in health care – yet little is known about the paradigm (including burden) in LMICs
- Knowledge and research gaps:
  - Sources of data
  - Settings and contexts
  - The scope and effectiveness of interventions
  - Measurement and monitoring of implementation progress
- Economic impact of diagnostic errors
- The role of human factors in addressing cognitive biases and improving overall system design

Key considerations for the way forward

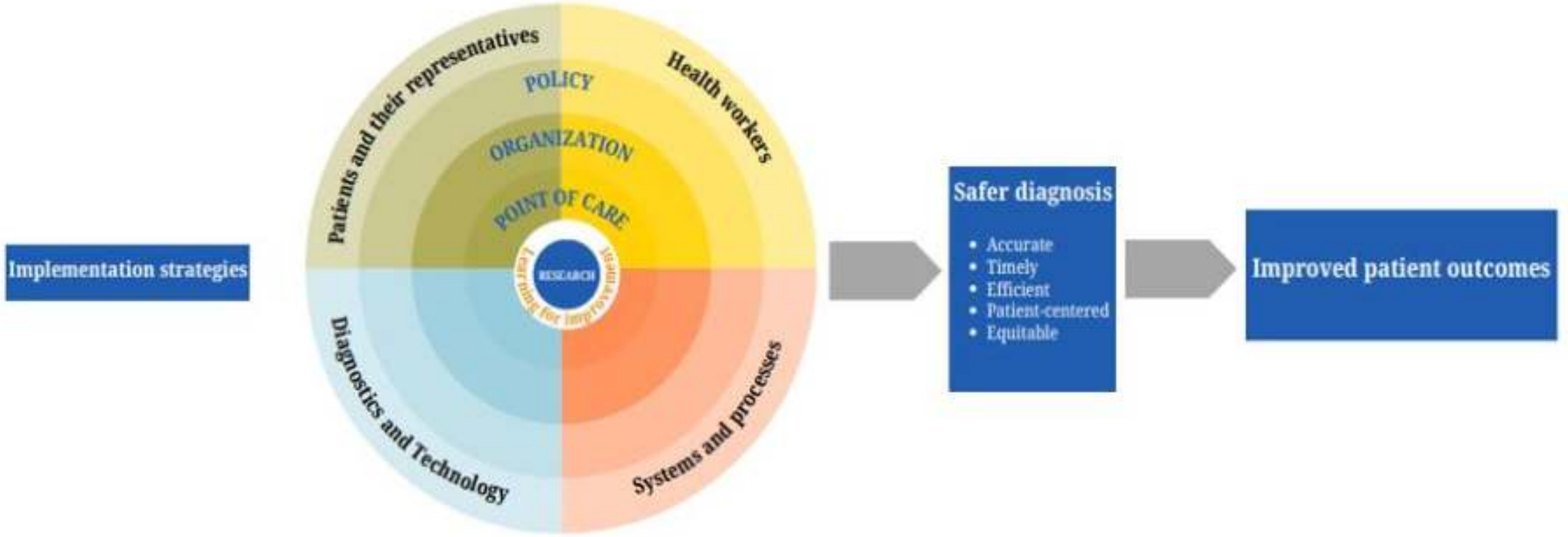
- Shared mental model: patient safety is not the absence of harm but the presence of safety, diagnostic safety is fundamental to patient safety
- Achieving diagnostic excellence: minimal resources, effective, efficient and feasible evidence-based interventions that maximize patient experiences and outcomes, and help to manage and communicate uncertainty to patients
- Investment in research: settings, diseases, effectiveness of interventions
- Focus on measurement and monitoring progress
- Learning from aviation: safety first
- Making the change implies profound systemic challenges:

- Across several domains: patients, health workforce, systems and processes, diagnostics and technology
- At different levels: policy, organizational and point-of-care
- With a focus on building learning systems

What do we know and what do we still have to learn?

- The attributes and causes of diagnostic errors
- The key factors to be addressed if we want to reduce the burden of diagnostic errors and the kay players
- The colour theme of World Patient Safety Day
- Where to find information about World Patient Safety Day https://www.who.int/campaigns/world-patient-safety-day/world-patient-safety-day-2024
- Whom to contact in WHO for any questions related to patient safety patientsafety@who.int
- WHO Patient Safety Flagship team (who dives and who eats Indian food)
- We know each other better: key subject matter experts, patient advocates, country representatives, professional organizations, WHO leadership, regional focal points and technical teams

What do you think about the proposed implementation model for improving diagnostic safety?



Group Presentations

By Rapporteurs from
the four groups

World Health Organization

World Patient Safety Day 17 September 2024




Diagnostic Safety- Implementation model

Reporting back by groups

Group No.1: Healthcare worker

World Patient Safety Day 17 September 2024

1. Are the proposed attributes of diagnostic safety comprehensive and relevant to all health care settings?

- General reflections:
  - Diagnostic accuracy is not static, but a continuous process
  - The attributes are not mutually exclusive
  - We did not consider whether the attributes are measurable

World Patient Safety Day 17 September 2024

World Health Organization

1. Are the proposed attributes of diagnostic safety comprehensive and relevant to all health care settings?

- Accuracy
- Timely → **Well-timed**
- Efficiency
- Patient centered
- Equitable
- **Collaborative**
- **Ethical**
- **Sufficiency**

World Patient Safety Day 17 September 2024

World Health Organization

2. What do you think of the implementation model in terms of structure, relation between different elements and completeness?

- A lot of discussion and little agreement:

Consider:

- Should there be a ‘just culture’ component as a prerequisite for implementation of any intervention?
- Should the attributes in this model be pillars of diagnostic safety, as they are not measurable.

3. What do you think of the proposed interventions. Are they comprehensive, feasible and do they cover all elements within the specific domain and level of implementation?

- Great set of interventions, but there are always more.
- Important to contextualize and prioritize:
  - Country
  - Setting
- General suggestion: Make the language more actionable:
  - Promote → Practice
  - Provide → Ensure

World Patient Safety Day 17 September 2024

World Health Organization

4. Are there any best practices or innovative approaches that can be incorporated into the framework?

- Many can be implemented but it is important to contextualize
- Evaluate, measure and improve
- Clear need for more research!

Diagnostic Safety-Implementation model

Reporting back by groups

Group No. 2: Patient and family engagement

World Patient Safety Day 17 September 2024

1. Are the proposed attributes of diagnostic safety comprehensive and relevant to all health care settings?

- The group believes they don't include the elements of the Strategic Objective 4 of the Global Patient Safety Action Plan 2021-2030
- The attributes were written from the perspective of the providers/policy-makers rather than from the patient perspective
- The group noted lack of patient self-diagnosis and care at home
- We also missed the risk of inequity bias
- Needs to explicit that screening is not included

2. What do you think of the implementation model in terms of structure, relation between different elements and completeness?

- There is a lack of patient agency throughout the document.
- We would like to see more collaborative working and co-production.
- The group concluded that the diagram made the process look too industrialized and tidy.

3. What do you think of the proposed interventions. Are they comprehensive, feasible and do they cover all elements within the specific domain and level of implementation?

- The final layer of interventions concerning patients and patient advocates is meant “to” patients and not what patients can actually do to improve patient safety, e.g. providing accurate information and actively following up on results.
- Some of the interventions should be co-created *with* patients instead of *for* patients.

World Patient Safety Day 17 September 2024

World Health Organization

4. Are there any best practices or innovative approaches that can be incorporated into the framework?

- IOM Checklist and toolkit.
- Positive patient identification.
- Secure first 60 seconds for patient: not interrupting patients for 60 seconds.
- Rapid review access.

Diagnostic Safety- Implementation model

Reporting back by groups

Group 3. : Systems & Processes

World Patient Safety Day 17 September 2024

1. Are the proposed attributes of diagnostic safety comprehensive and relevant to all health care settings?

- Should evidence-based be incorporated into the criteria for safer diagnosis
  - This could also be rolled up into the accuracy criteria.
  - Evidence can be biased—RCTs often exclude the most vulnerable
  - Efficiency could also be linked to evidence (doing what is most practical)
- Should we start before a patient presents with a problem—inform the population of when we they may have a problem→ related to pre-care and access
- "Patient-centred" could be "People-centered" and/or "Patient & Family-Centred"
- People-centred extends beyond the disease
  - OECD domains of people-centred—Voice, choice, co-production, integration, and experience
  - Context and environmental and social factors beyond the clinical diagnosis
- An alternative outcome of diagnosis can be a non-diagnosis depending on patient context and preferences
- Relevant to all health care settings

2. What do you think of the implementation model in terms of structure, relation between different elements and completeness?

- Where is the role of leadership?
  - Cuts across – should use the table with the diagram together, they complement each other
- Focus on processes (routine activities) vs. thinking and evaluation
- Take out the circle? Simplify to a set of directions for implementing the various intervention.
- Add (at the first arrow)
  - Barriers and facilitators (leadership also could be here).
  - Resources/financing
  - Governance and legal environment
- Broaden outcomes (broader, patient, social outcomes, equity, efficiency, environmental, health system improvement→ feedback into the system).
- Add Monitoring and Evaluation (at second arrow) from multiple perspectives (including, e.g. PROMs and PREMs, etc)

3. What do you think of the proposed interventions. Are they comprehensive, feasible and do they cover all elements within the specific domain and level of implementation?

- Add integrated component (reduce duplication) to workflow
- Communication between organisations
- Improved referral systems.
- Use of PREMs and PROMs related to diagnostic safety (policy level to develop, and org. to use them).
- Mechanisms to collect and share mechanisms of patient safety, including from the patient perspective
- Data on timeliness

3. What do you think of the proposed interventions. Are they comprehensive, feasible and do they cover all elements within the specific domain and level of implementation?

- Add education of health care workers
- Add setting standards for diagnosis processes (regulation)→ link with non-punitive culture
- Learning systems in place
- Good governance, resolution for conflicts of interest.
- Secondary use of data for patient safety monitoring
- Policies to tackle fragmentation of care
- Polies to promote and integrate health data and data infrastructure.
- Cross border treaties and infrastructure to standardise incident reporting.
- Return on investment for patient safety—justify the study (how long it takes to pay off).
- Establish legal safeguards for health workers (related to disclosing diagnostic errors)
- Safeguards for diagnostic process to avoid misdiagnosis (checklist or some other tool).

World Patient Safety Day 17 September 2024

World Health Organization

3. What do you think of the proposed interventions. Are they comprehensive, feasible and do they cover all elements within the specific domain and level of implementation?

- Optimizing teamwork includes patients/families
- Team/integrated involvement preferable to “second opinion” which can threaten timeliness, e.g. multidiscip tumour board
- Add escalation of referrals to higher levels into process
- Cancer screening should be broadened to include other
- Measures of timeliness, e.g. sepsis clock

World Patient Safety Day 17 September 2024

World Health Organization

4. Are there any best practices or innovative approaches that can be incorporated into the framework?

- See slide 3

Diagnostic Safety -Implementation model

Reporting back by groups

Group No. 4: Diagnostics and Technology

World Patient Safety Day 17 September 2024

World Patient Safety Day 17 September 2024

World Health Organization

1. Are the proposed attributes of diagnostic safety comprehensive and relevant to all health care settings?

- Collaborative
- Safe
- Local Context Sensitive
- Evidence-based
- Patient-Centered: Evidence based / Communicated to patient

2. What do you think of the implementation model in terms of structure, relation between different elements and completeness?

- Research in the Center (Can we move out)
- How to show that it is Patient-Centered?
- HFE to be Cross Cutting
- Macro / Meso / Micro (Point of Care!)
- How can it show feedback loops?

Note: to have HFE expert to look the model and give suggestions

World Patient Safety Day 17 September 2024

World Health Organization

3. What do you think of the proposed interventions. Are they comprehensive, feasible and do they cover all elements within the specific domain and level of implementation?

- Healthcare Leadership Interventions
- Healthcare Financing Interventions
- Need to go beyond the assumption that EHR exists in all settings (LMIC)

World Patient Safety Day 17 September 2024

World Health Organization

Interventions Concerning Technology

Policy	Organizational level	Point of care
Ensuring national oversight of EHR's and AI	Deploying and maintaining an EHR	Using EHR's to their full advantage
Ensuring national oversight, protection, and useability of EHR's and AI	Best Practices in EHR Implementation (Change Management)	
Establishing national telemedicine resources and policies	Enabling telemedicine and promoting its use	Using telemedicine and patient portals
Providing research funding for technology development and testing	Providing patient portals and access to their data	Using decision support tools, including AI tools
HTR	HTA	
	Using trigger tools to monitor test follow-up	
ADD: • **Using Technology Interventions for HIM Systems** • **Data Sharing & HIE Policies**		

World Patient Safety Day 17 September 2024

World Health Organization

4. Are there any best practices or innovative approaches that can be incorporated into the framework?

- Clinical Auditing

Discussion and Q and A

Moderator

Helen HASKELL

President, Mothers Against Medical Error USA

World Health Organization

World Patient Safety Day 17 September 2024

Patient Safety: the communication science perspective

Prof Annegret HANNAWA
Director, Center for the Advancement of Healthcare Quality & Safety
Faculty of Communication, Culture & Society, Università della Svizzera italiana,
Italy

World Health Organization

World Patient Safety Day 17 September 2024

Patient Safety: The Role of Communication Science

Prof. Dr. Annegret Hannawa
Università della Svizzera italiana (USI)
European Institute for Safe Communication (EISC)
Johns Hopkins University Bloomberg School of Public Health

Diagnosis

is about Uncertainty Reduction.


Communication
is our most innate
safety process.


In healthcare,
we don‘t use our communication much for safety.


Communication doesn‘t break down.
It doesn‘t even come to exist.

Poor communication harms

The Story of the „Tilt Table Torture“

Good communication heals

The Story of the „Angel Nurse in a Cappuccino Gown“


Uncertainty is good for safety


Uncertainty is good for safety
because it makes us communicate.

Diagnostic Errors

Cognitive issues are involved in about 75% of the cases.

Communication

Is the correction mechanism.

“Two pairs of eyes see more than one”

But this only serves safety if the perspectives are aligned.

Unsafe communication

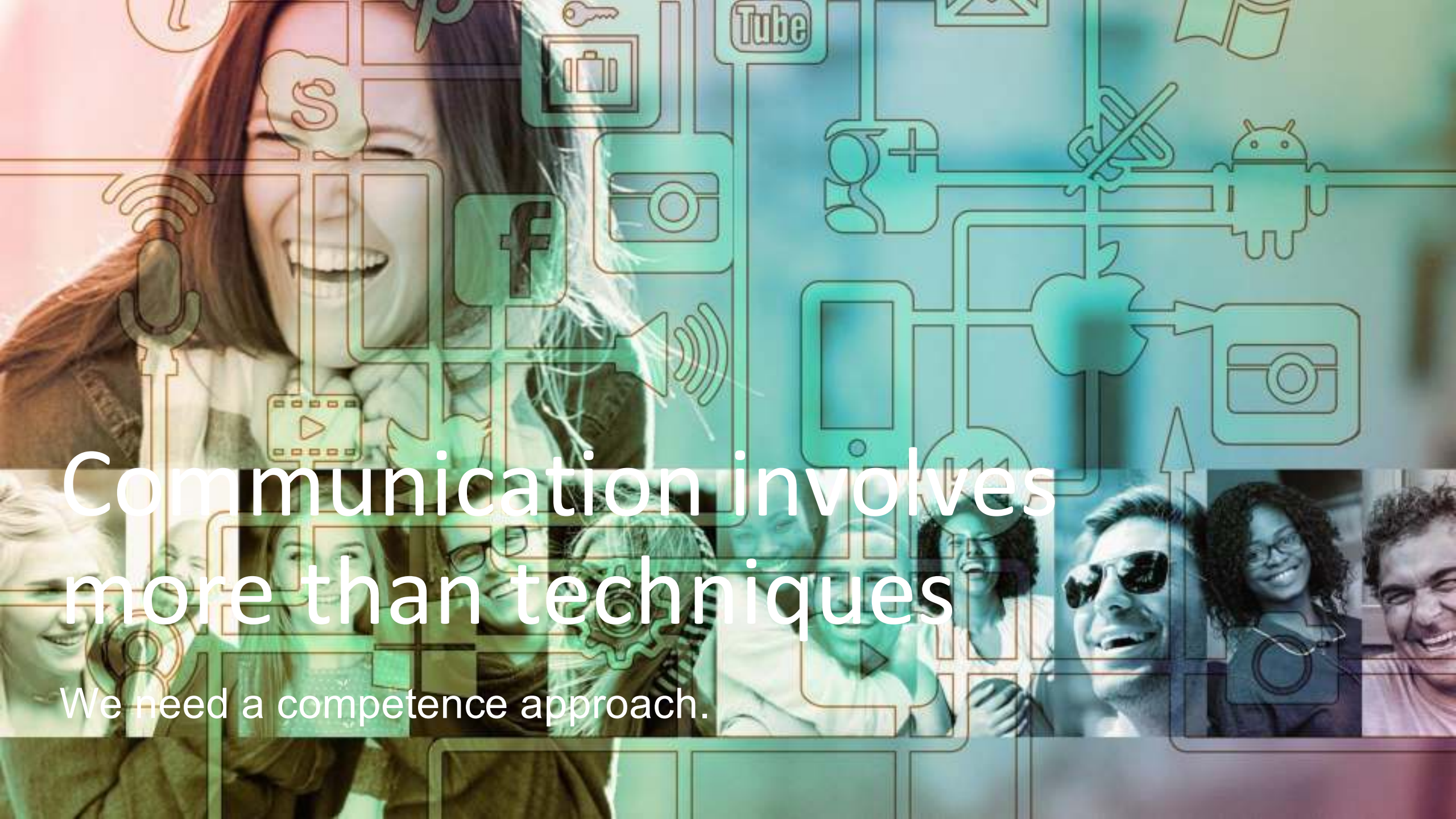
makes us aggressive,
blind and mute.


Unsafe
communication
is expensive.

The danger of silos


The attainment of a shared understanding
paves the path to safe action.


30
50
RED ROUTE
CLEARWAY
No stopping
Except
local buses
Look Left
Also
Check Service
Road Clear
GIVE
WAY



Communication involves more than techniques

We need a competence approach.


Uncertainty is
messy

Uncertainty is messy

We must use our communication to come out clearer on the other end.

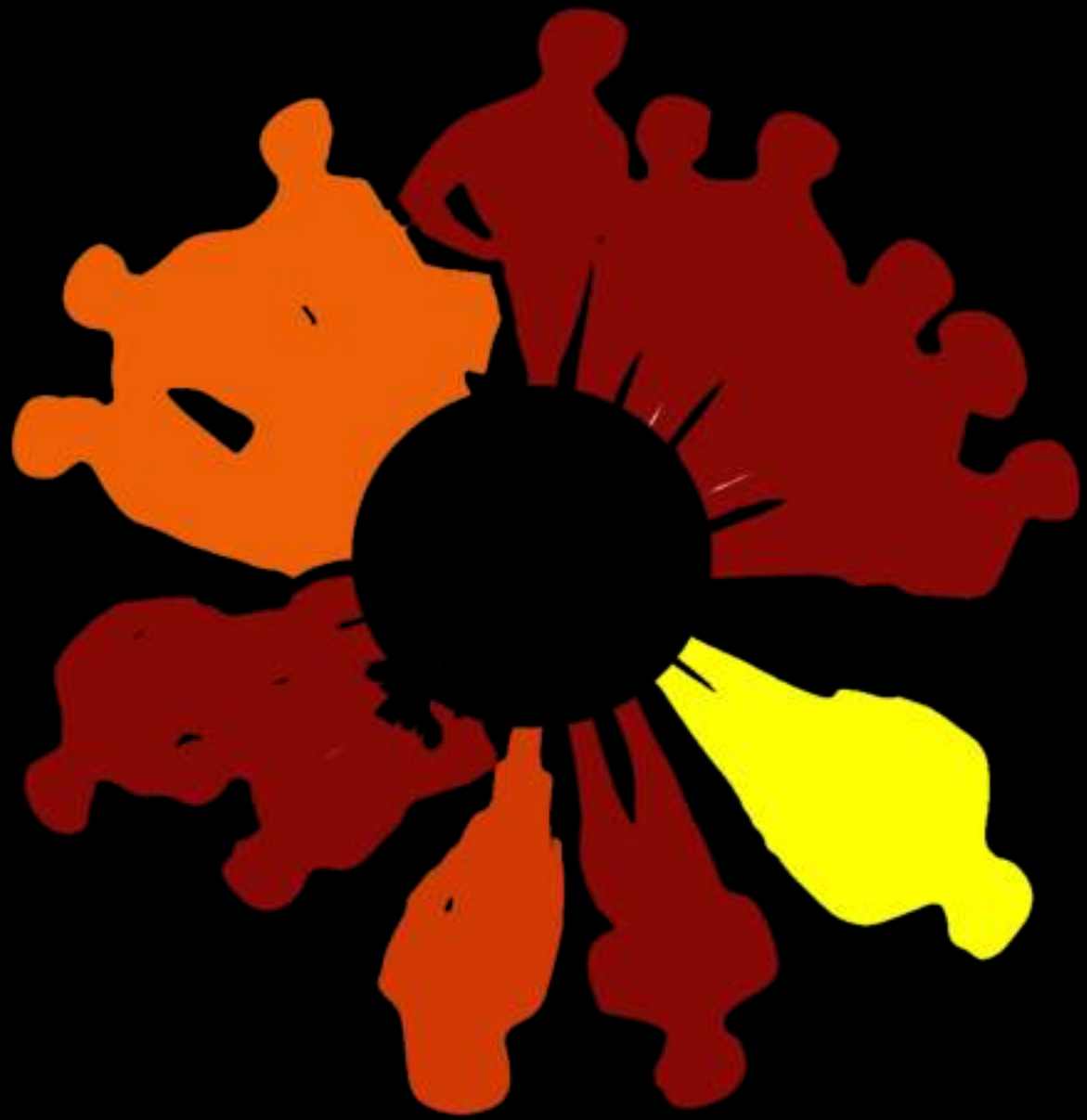
Communication is a two-edged sword

If we communicate competently, we pave the path for safe care.

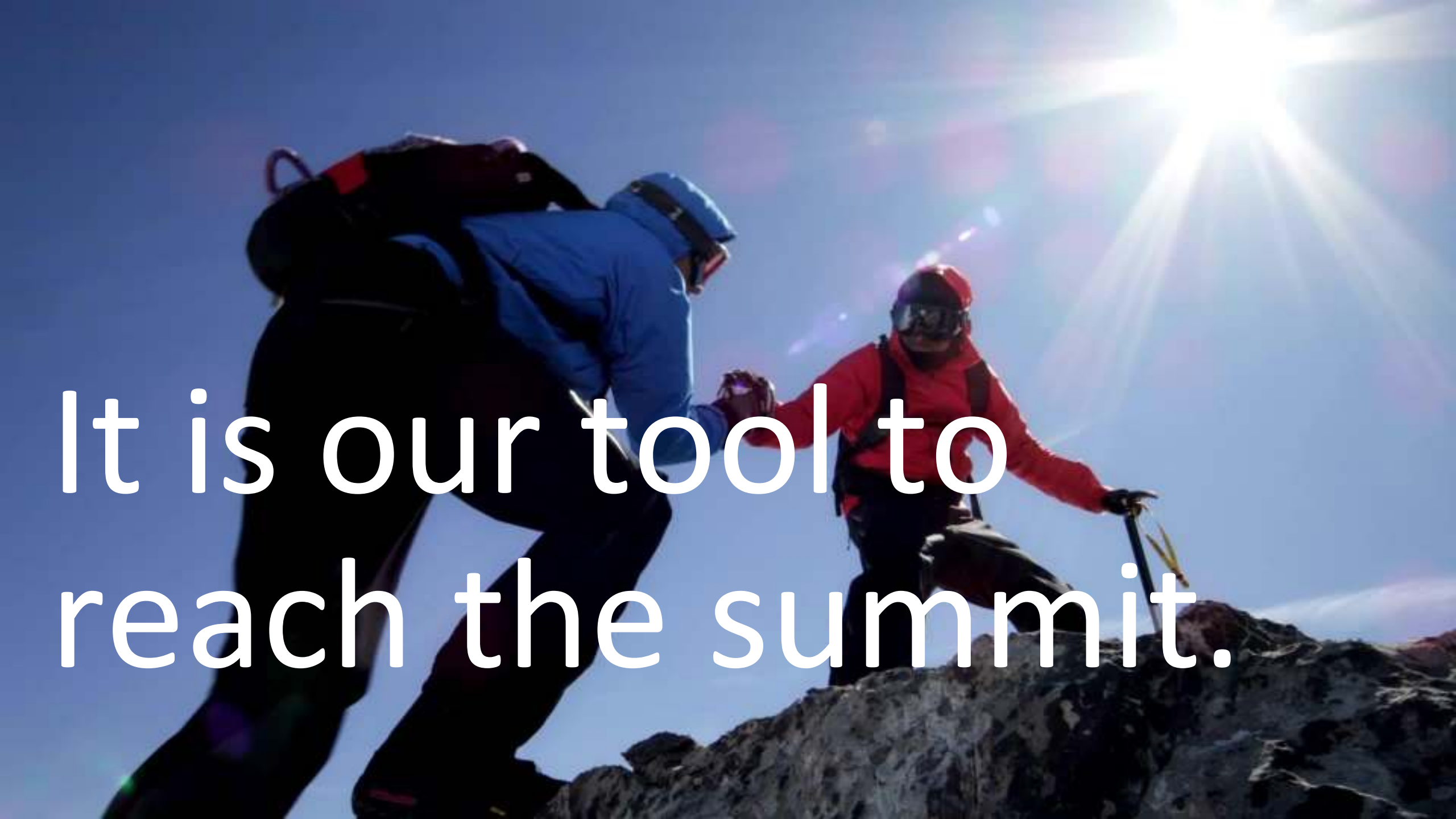
If we communicate incompetently, we can cause (more)

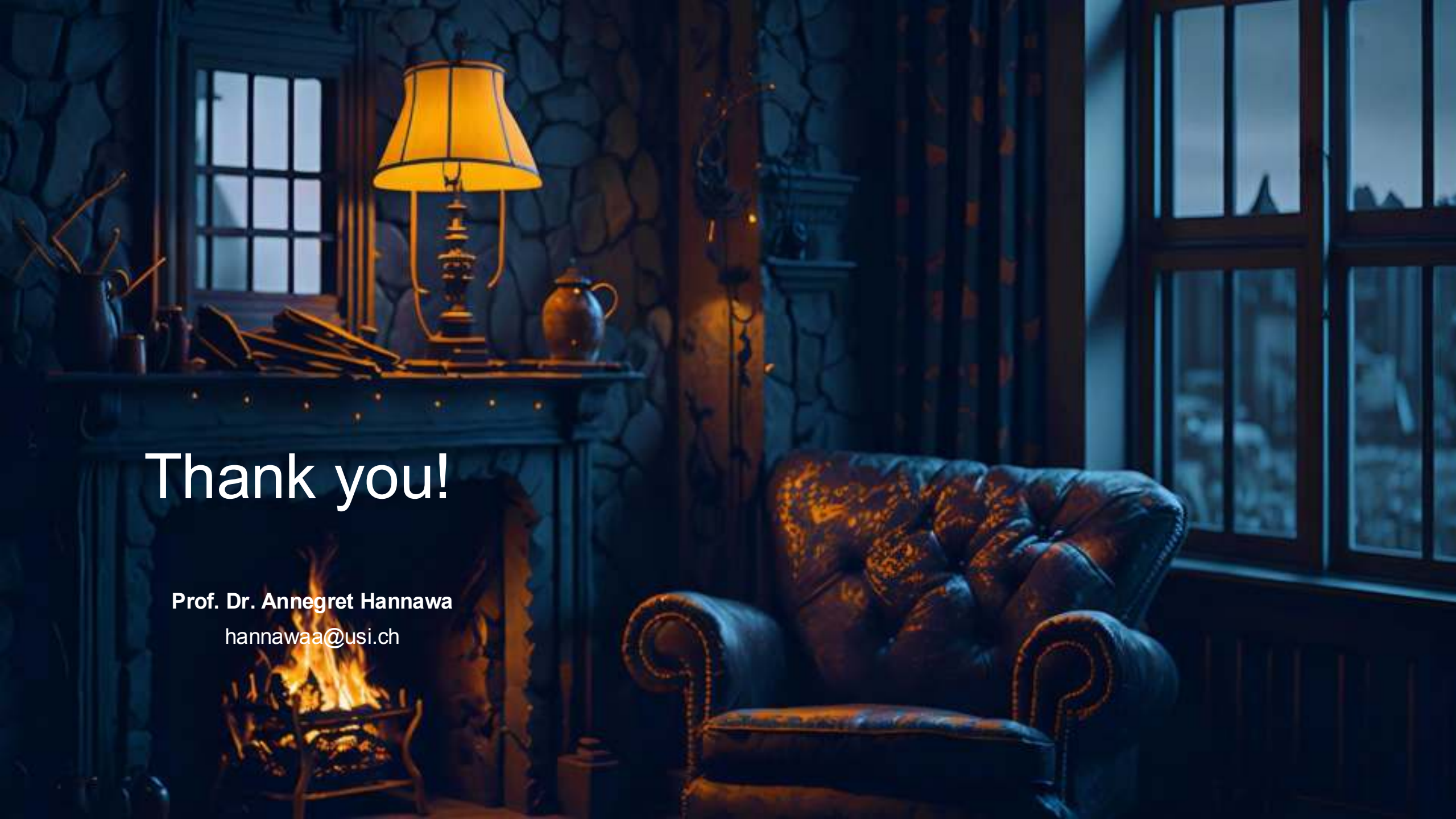
Communication

Is the most powerful resource we have.




Communication is not
a Mt. Everest


It is our tool to
reach the summit.



Thank you!

Prof. Dr. Annegret Hannawa
hannawaa@usi.ch

Way forward

Sir Liam DONALDSON
WHO Envoy for
Patient Safety
WHO headquarters
Switzerland

World Health Organization

World Patient Safety Day 17 September 2024

World Patient Safety Day 2024

WHO Global Consultation

Improving diagnostic safety and implementing the Global Patient Safety Action Plan 2021-2030

10th – 12th September 2024
Geneva, Switzerland

World Health Organization

World Patient Safety Day 17 September 2024

Session 4 - The path to safer care:

Implementing the Global Patient Safety Action Plan (GPSAP) 2021-2030

Chairperson
Sir Liam DONALDSON
WHO Envoy for Patient Safety
WHO headquarters
Switzerland

Co-chairperson
Ms Sue SHERIDAN
Founding member,
Patients for Patient Safety, US
USA

World Health Organization

World Patient Safety Day 17 September 2024

Implementing the GPSAP 2021-2030

Dr Irina PAPIEVA
Patient Safety Flagship (PSF)
Integrated Health Services (IHS)
WHO, HQ

Dr. Nikhil Gupta
Technical officer
PSF/IHS
WHO HQ

Dr. Ayda Taha
Technical officer
PSF/IHS
WHO HQ

Alexandra Shaw
WHO consultant
PSF/IHS
WHO HQ

Dr. Priyadarshani Galappatthy
WHO consultant
PSF/IHS
WHO HQ

World Health Organization

World Patient Safety Day 17 September 2024

Implementing Global Patient Safety Action Plan 2021-2030

World Patient Safety Day 17 September 2024

World Health Organization

WHO Patient Safety Flagship Programme

Global Patient Safety Action Plan 2021 -2030

World Patient Safety Day

Global Patient Safety Challenge Medication Without Harm

Global Patient Safety Collaborative

Technical guidance and tools to improve patient safety

World Patient Safety Day 17 September 2024

World Health Organization

72nd World Health Assembly (WHA)
May 2019

- ✓ Adopted WHA resolution on **Global action on patient safety** (WHA72.6)
- ✓ Recognized **Patient Safety as a global health priority**
- ✓ Established an annual **World Patient Safety Day** on 17 September
- ✓ Formulate a **Global Patient Safety Action Plan**, aligned with SDGs

World Health Organization

SEVENTY-FOURTH WORLD HEALTH ASSEMBLY **WHA74(13)**
Agenda item 13.1 **31 May 2021**

Global action on patient safety

The Seventy-fourth World Health Assembly, having considered the consolidated report by the Director-General,[1]

Decided:

(1) to adopt the global patient safety action plan 2021–2030;

(2) to request the Director-General to report back on progress in the implementation of the global patient safety action plan 2021–2030 to the Seventy-sixth World Health Assembly in 2023 and thereafter every two years until 2031.

Seventh plenary meeting, 31 May 2021

Launch of Global Patient Safety Action Plan 2021–2030

4 August 2021

World Patient Safety Day 17 September 2024

World Health Organization

Mission

Drive forward policies, strategies and actions based on science, patient experience, system design and partnerships to eliminate all sources of avoidable risk and harm to patients and health workers

Goal

Achieve the maximum possible reduction in avoidable harm due to unsafe health care globally

Vision

A world in which no one is harmed in health care, and every patient receives safe and respectful care, every time, everywhere

GPSAP 2021-2030: Strategic Objectives

Strategic Objective 4

Patient and family engagement

Strategic Objective 3

Safety of clinical processes

Strategic Objective 5

Health worker education, skills and safety

Strategic Objective 2

High-reliability systems

Strategic Objective 6

Information, research and risk management

Strategic Objective 1

Policies to eliminate avoidable harm in health care

Strategic Objective 7

Synergy, partnership and solidarity

World Patient Safety Day 17 September 2024

World Health Organization

Framework for Action - The 7x5 Matrix

World Patient Safety Day 17 September 2024

Modes of implementation

GPSAP 2021-2030: Monitoring implementation progress

Member State survey analysis :	Burden of Unsafe Health care:	Case Studies:	Comparative Analyses:
• Performance on various indicators linked with strategic framework of GPSAP • Compilation and description of actions taken by countries • Summary of progress across WHO regions and income levels	• Evidence on overall burden of unsafe practices • Analysis within specific population groups, clinical domains, and major sources of harm	• Examples of countries developing patient safety solutions • Feature stories on global initiatives and interventions	• Insights into patient safety policies and legal frameworks • Patient engagement and educational initiatives • Reporting and learning systems • Stakeholder involvement

Strategic Objective 1

Policies to eliminate avoidable harm in health care

Make zero avoidable harm to patients a state of mind and a rule of engagement in the planning and delivery of health care everywhere

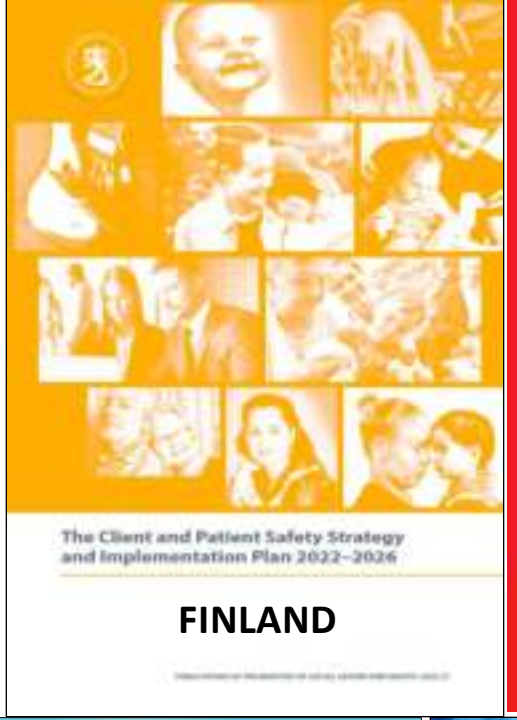
Strategic Objective 1: Key implementation areas

- **Policy dialogue, policy and strategy development and implementation**: structured support to countries (e.g., GPSC) vs individual requests; dedicated PS strategies vs integrated approaches
- **Resource mobilization**: global level
- **Supportive legislation and regulatory frameworks**: bespoke support to the countries
- **Safety standards, regulation and accreditation**: policy briefs, technical series, working documents
- **Global initiatives**: World Patient Safety Days, Global Patient Safety Challenges

First Challenge: 2005
Clean care is safer care

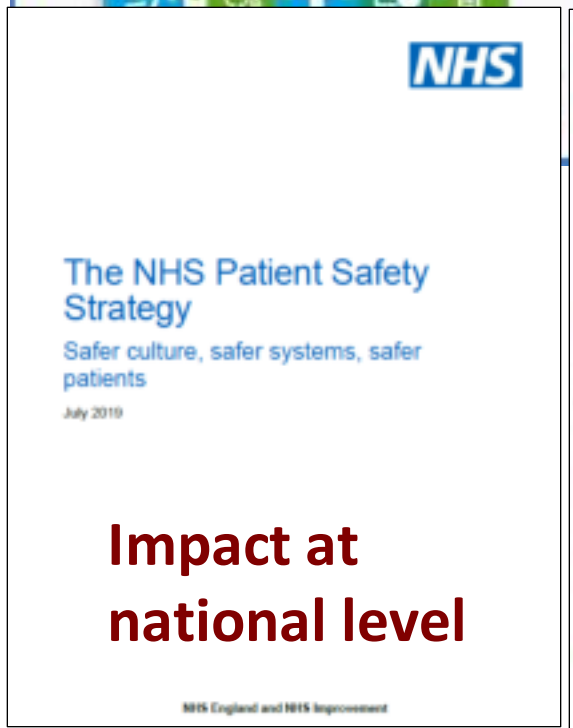
Second Challenge: 2007
Safe Surgery Save Lives

Third Challenge: 2017
Medication without Harm



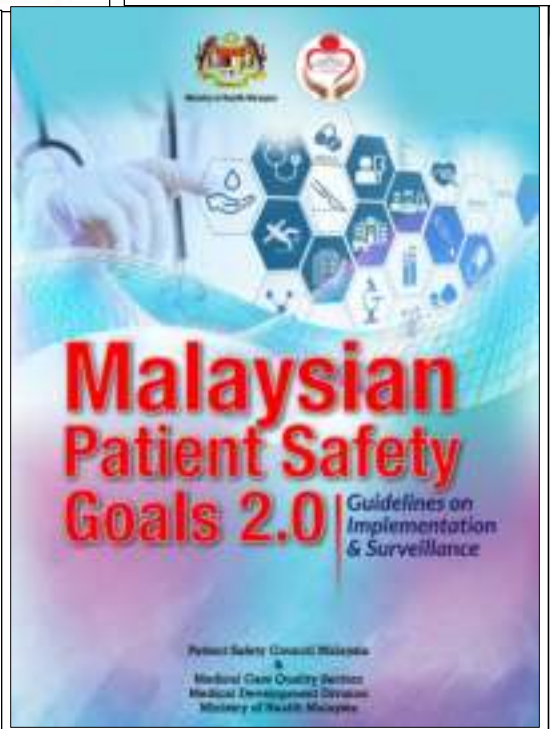
FINLAND

KENYA



Impact at national level

Republic of Ireland



CORE Indicator

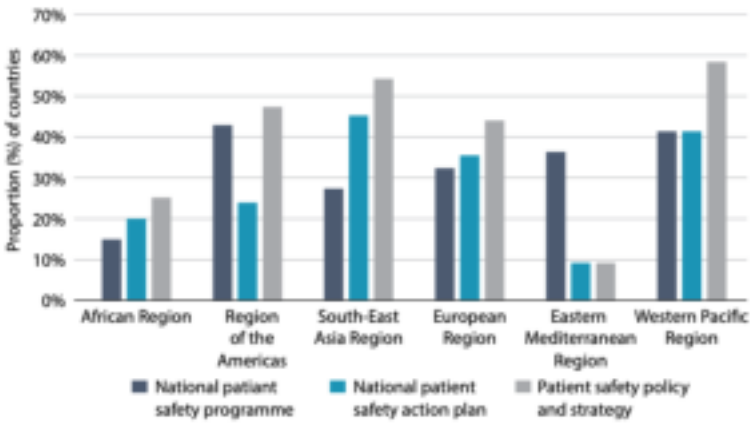
29%

Countries have developed a national patient safety action plan or equivalent

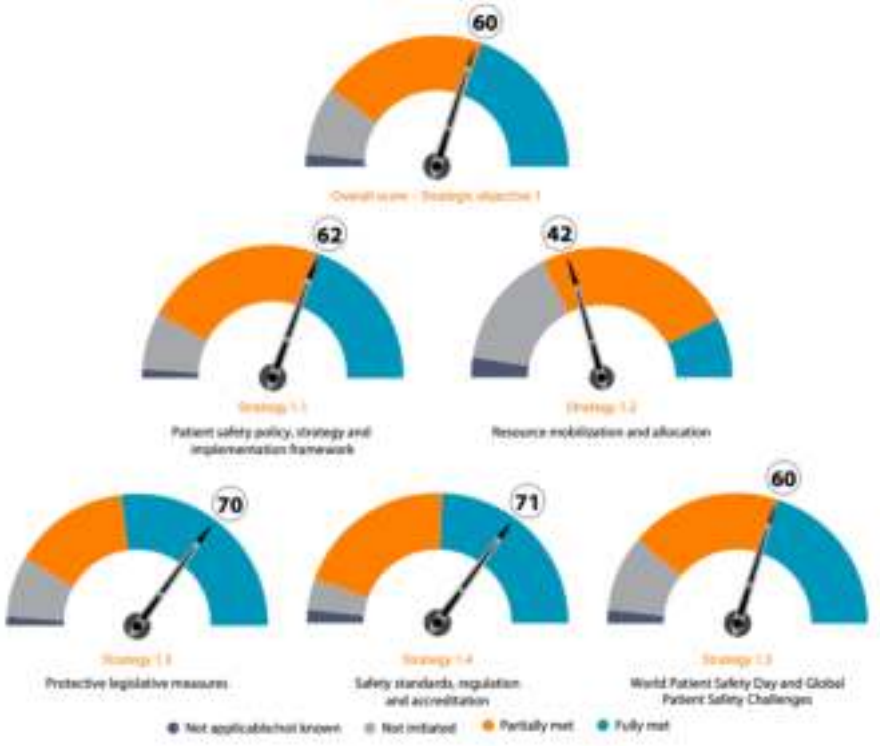
80%

World Patient Safety Day

Countries launched a national campaign on World Patient Safety Day

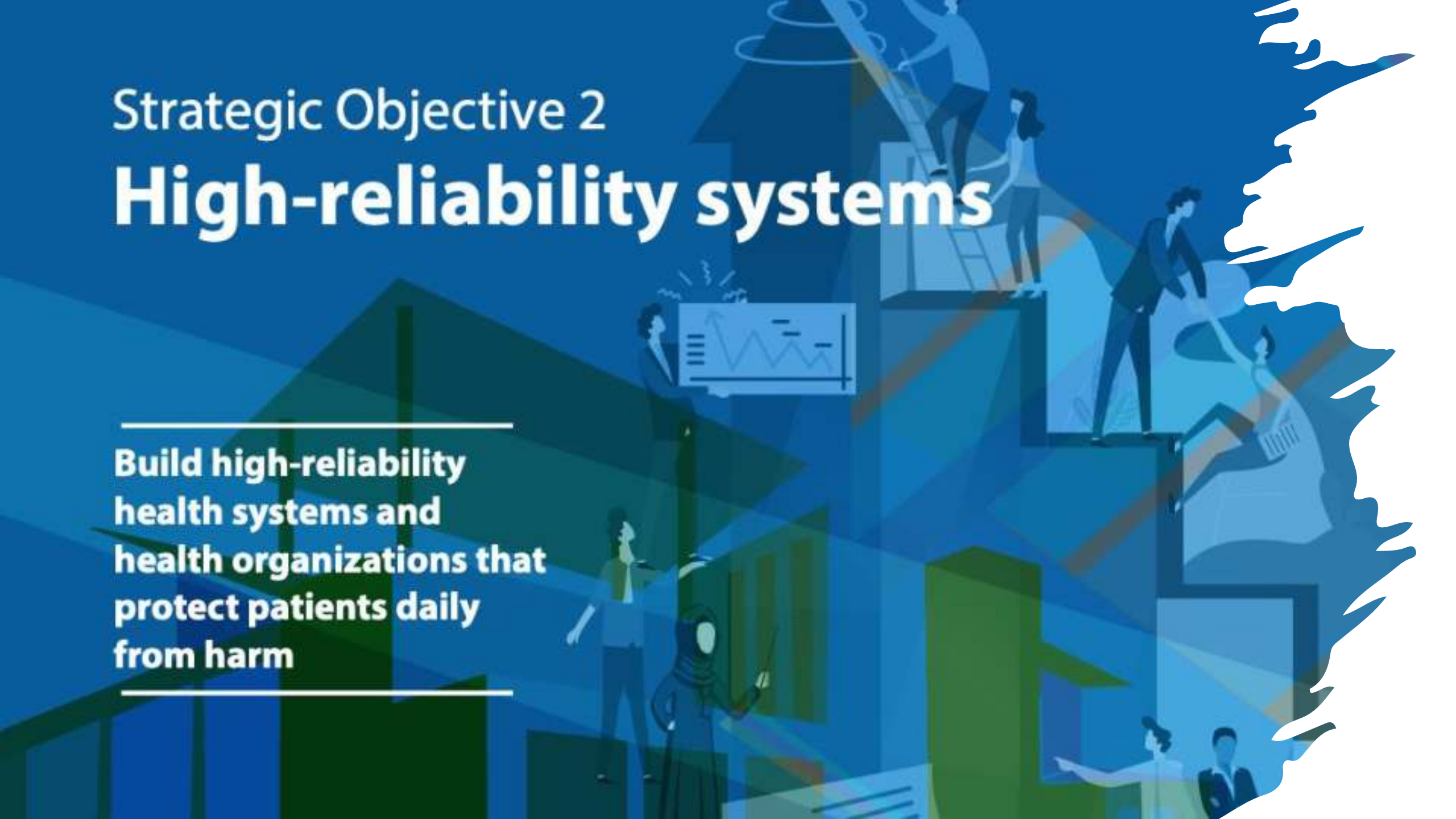


"Patient safety is a policy priority for most with some early implementers though grossly underinvested"



Key findings

- Patient safety is a national priority for most
- 32% countries have a patient safety program
- Only 11% countries have adequate finances
- Half of the countries have safety standards
- 31% countries are implementing all Global Patient Safety Challenges



Strategic Objective 2

High-reliability systems

Build high-reliability health systems and health organizations that protect patients daily from harm

Strategic Objective 2: Key implementation areas

- **Transparency, openness and no blame culture:** technical guidance (PS MIMs, PS Incident reporting and learning systems, Safety Culture guidance and assessment tool), policy dialogue, and targeted support to countries
- **Good governance for the health care systems**: advocacy and policy support
- **Leadership capacity for clinical and managerial functions**: technical guidance (Leadership Competency framework for Patient safety), bespoke support to the countries for policy action and competency development
- **Human factors/ergonomics for health systems resilience**: technical guidance (WHO-IEA practice guidance on applying human factors for patient safety), advocacy and policy dialogue
- **Patient Safety in emergencies and settings of extreme adversity**: advocacy (policy brief), research (Rapid review on implication of the COVID-19 pandemic for patient safety) and technical guidance (operational guidance on addressing patient safety in outbreaks and emergencies)

CORE Indicator

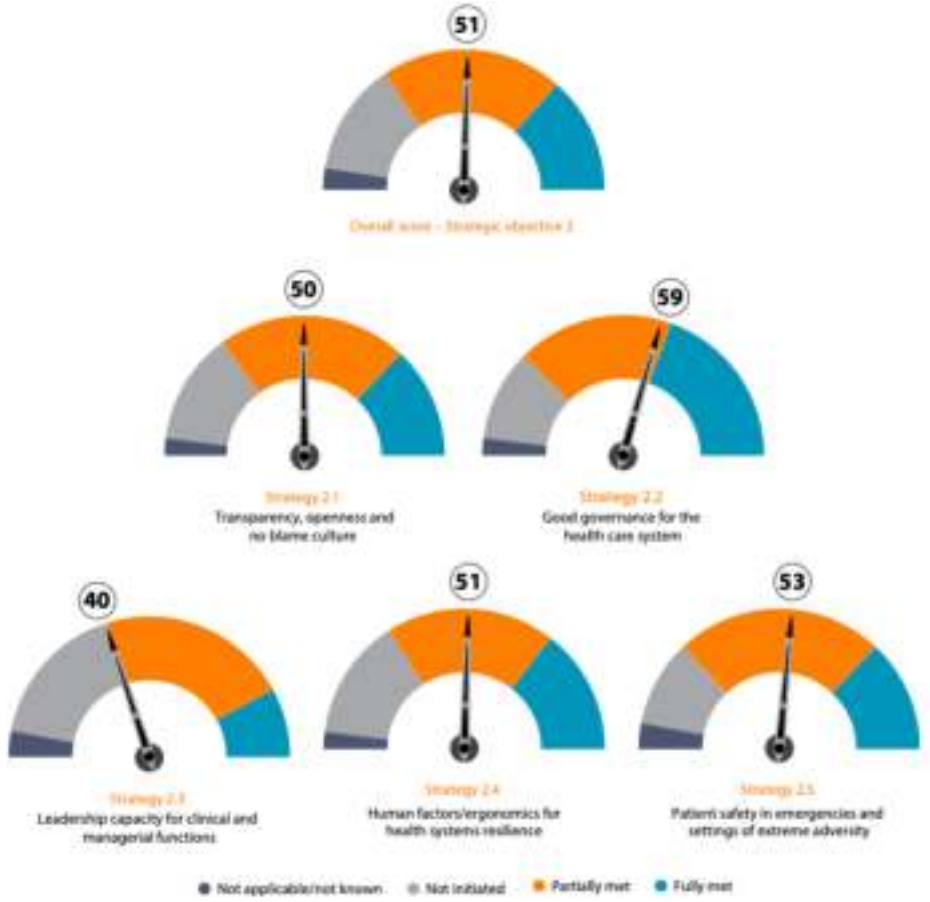
38%

Countries have implemented a system for reporting of never events

52%

Countries have appointed a national patient safety officer (or equivalent)

"We have solid foundation to evolve safety culture and high reliability systems"



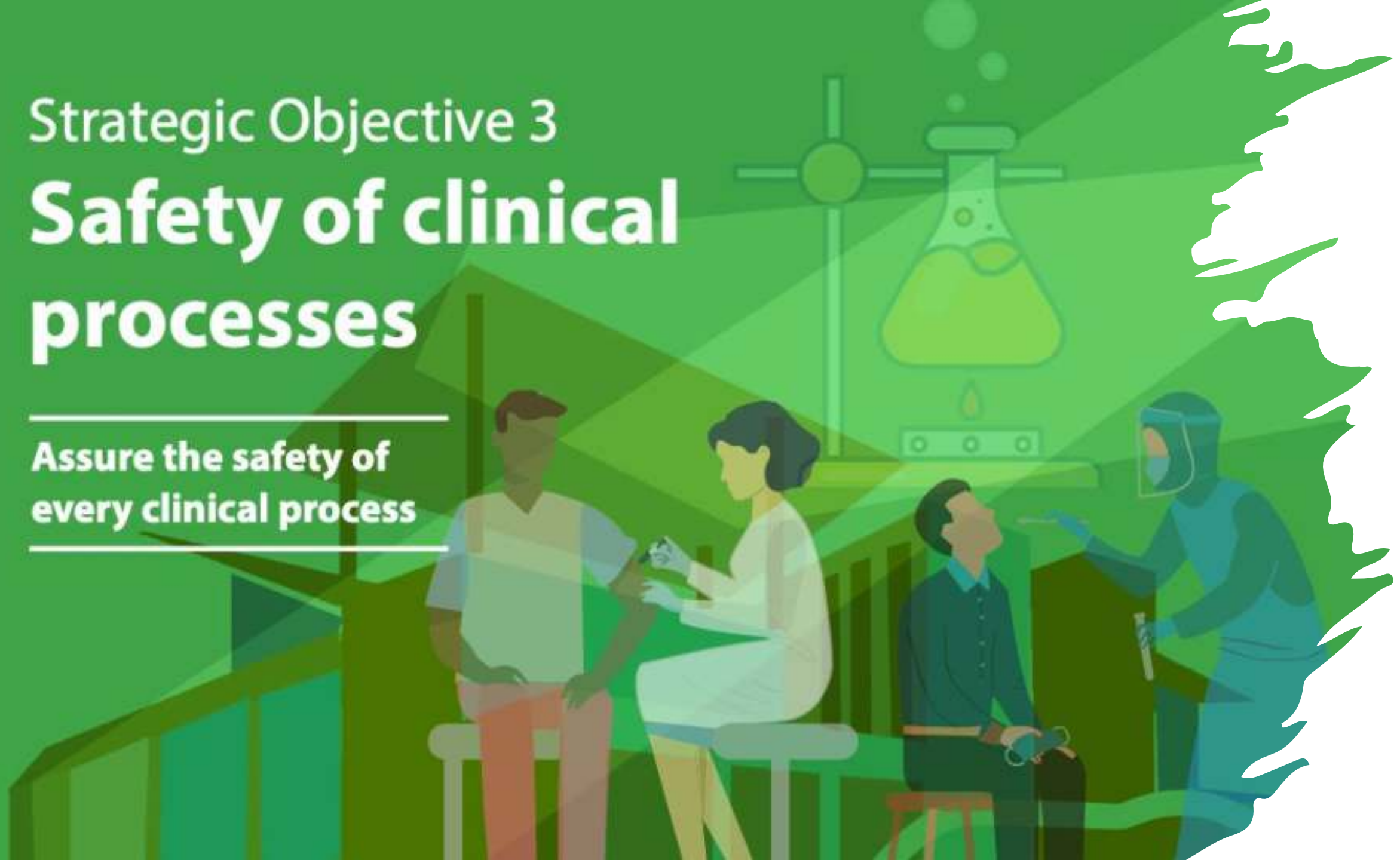
Key findings

- Only 26% have mechanism for blame free reporting
- Structural safety norms are not completely enforced in half the countries
- Only 25% conducts regular rehearsal (mock drills)
- 23% countries conducting regular safety culture survey
- 38% have established institutional framework

Strategic Objective 3

Safety of clinical processes

Assure the safety of every clinical process



Almost 50% of preventable patient harm is related to medications and therapeutic interventions.

One in 20 patients globally experience preventable medication related harm in medical care

A quarter of preventable harm is considered severe or life-threatening

Prevalence, severity, and nature of preventable patient harm across medical care settings: systematic review and meta-analysis

Maria Panagioti,[1] Kanza Khan,[1] Richard N Keers,[2] Aseel Abuzour,[2] Denham Phipps,[2] Evangelos Kontopantelis,[1] Peter Bower,[1] Stephen Campbell,[1] Razaan Haneef,[3] Anthony J Avery,[4] Darren M Ashcroft[1]

thebmj | BMJ 2019;366:l4185 | doi: 10.1136/bmj.l4185

Preventable medication harm across health care settings: a systematic review and meta-analysis

Hodkinson *et al. BMC Medicine* (2020) 18:313
https://doi.org/10.1186/s12916-020-01774-9

Patient Safety

GLOBAL LAUNCH

GLOBAL PATIENT SAFETY CHALLENGE ON MEDICATION SAFETY

29 March 2017, Bonn, Germany

World Health Organization

Strategies to support the Global Patient Safety Challenge: *Medication Without Harm*

- Technical resources and tools
- Medication safety webinar series

Medication safety campaign

KNOW.CHECK.ASK

Country support for the Medication Without Harm Challenge

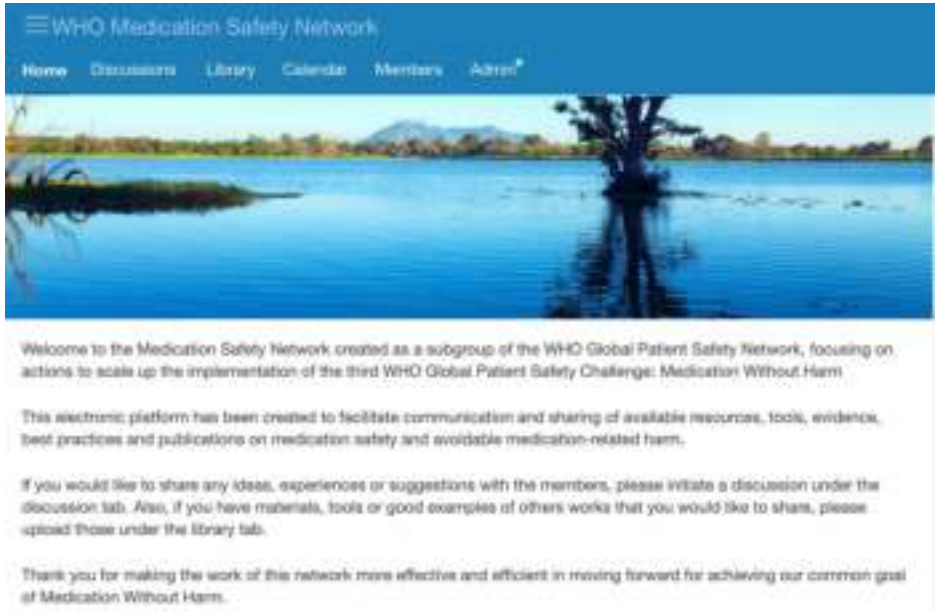
- Capacity building visits to ‘demonstration sites on medication safety’ Within the frames of the WHO Global Patient Safety Collaborative (GPSC)

Supporting GPSC countries for medication safety activities – India, Pakistan, Mongolia, Kenya, Ethiopia and Sri Lanka

Upcoming technical products to support the *Challenge*

- Medication safety in perioperative care
  - jointly with World Federation of Societies of Anesthesiologists (WFSA)
- Medication safety in maternal and newborn care
- Medication safety assessment tool
- Medication safety curriculum guide

Medication safety network for sharing information, a sub- group of GPSN



CORE Indicator

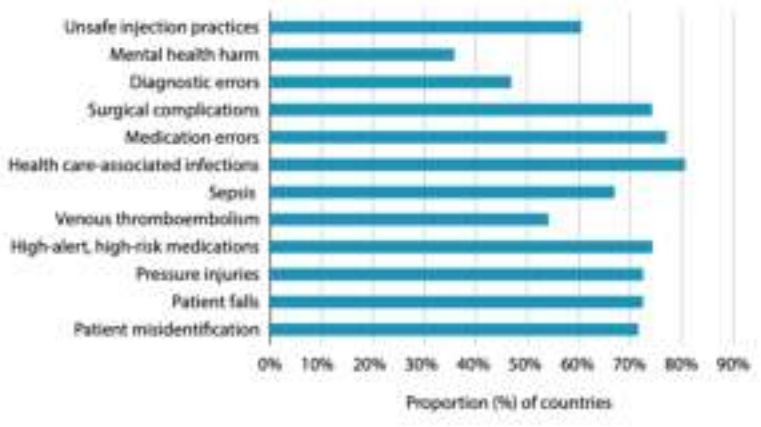
21%

countries have established target for reduction in medication related harm

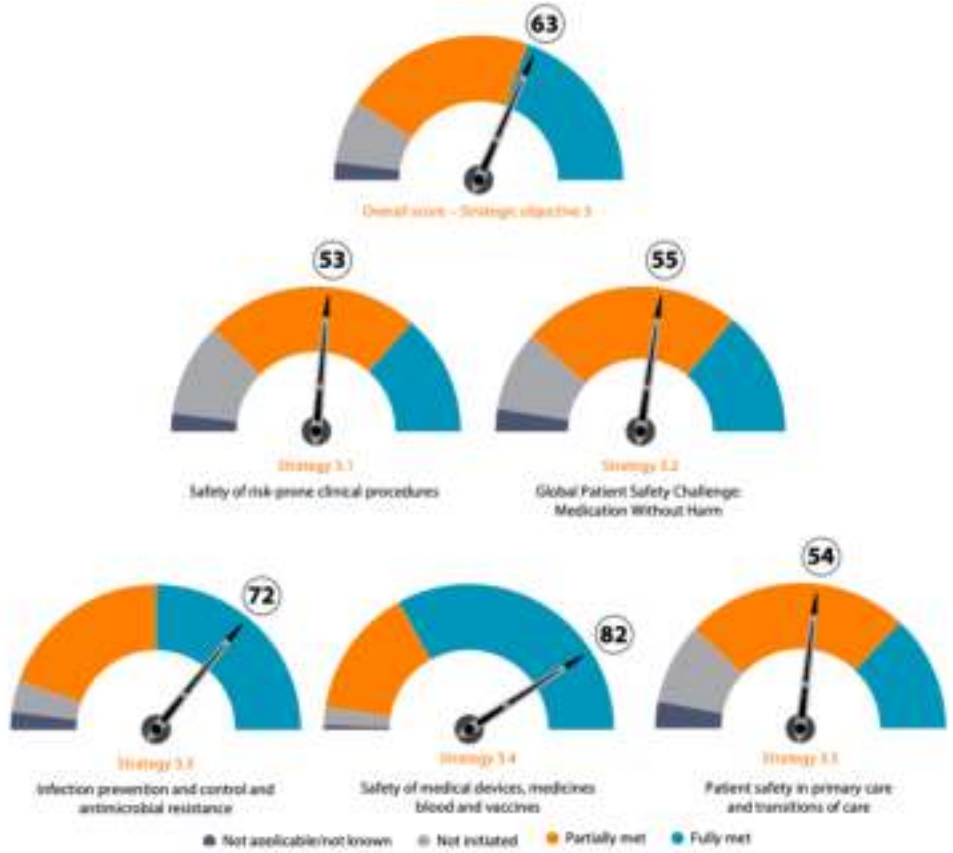
CORE Indicator

38%

countries have established target for reduction in Heath care associated infections (HAIs)



"Global Patient Safety Challenges have been instrumental in triggering clinical safety programs in countries "



Key findings

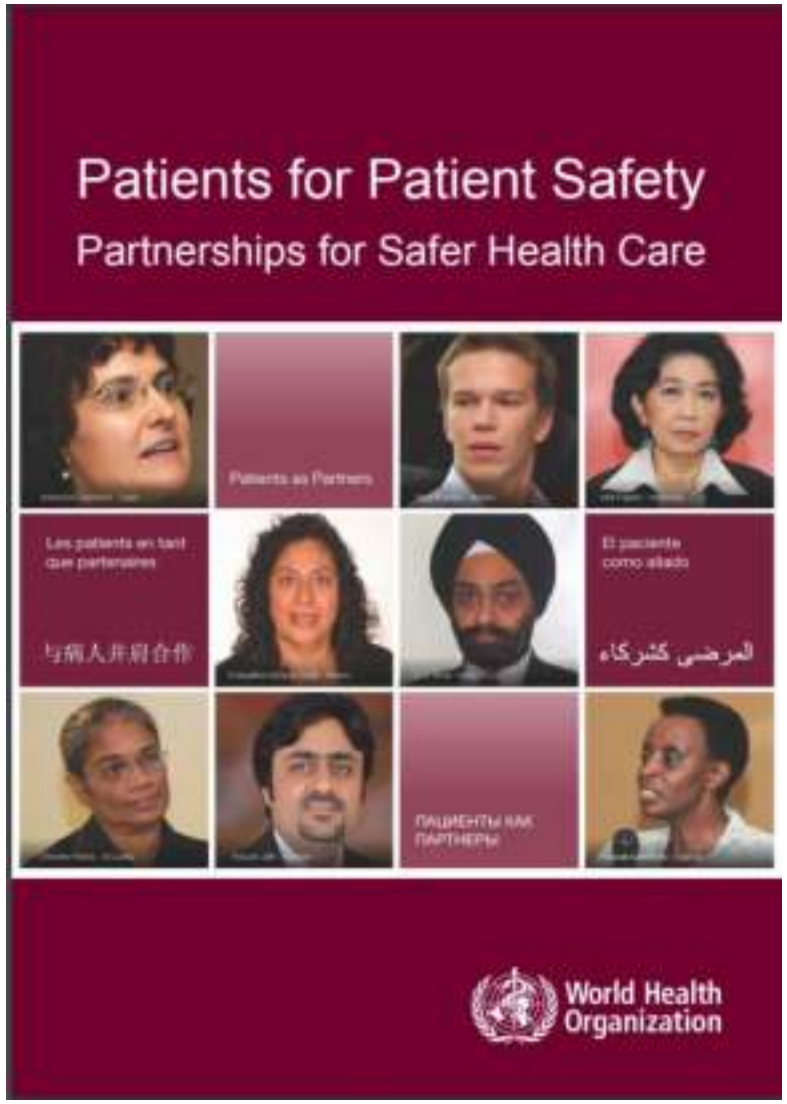
- HAIs and medication errors are priority areas for most of countries
- Mental health and palliative care are least addressed areas for patient safety
- 74% have endorsed global patient safety challenge on medication without harm
- 17% countries are implementing patient safety in primary care
- 72% have regulatory framework for safety of medical products

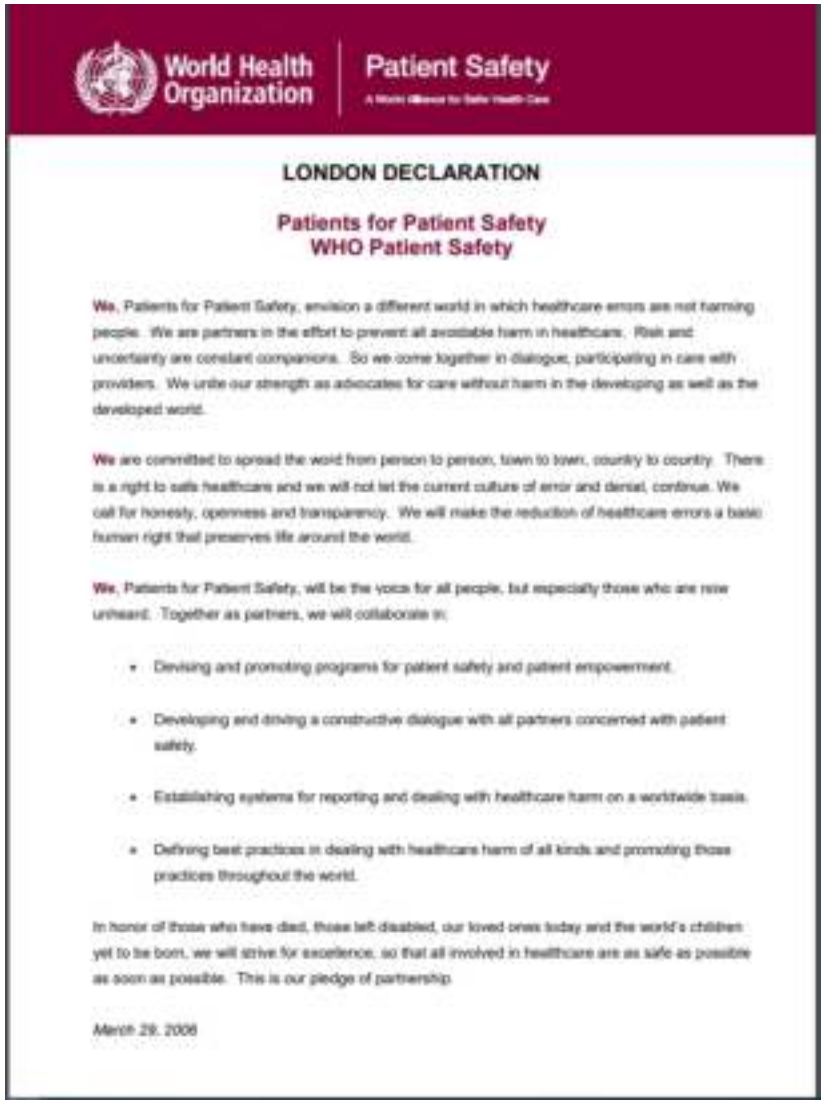
Strategic Objective 4

Patient and family engagement

Engage and empower patients and families to help and support the journey to safer health care

WHO Patients for Patient Safety Programme




World Health Organization | Patient Safety

LONDON DECLARATION

Patients for Patient Safety
WHO Patient Safety

We, Patients for Patient Safety, envision a different world in which healthcare errors are not harming people. We are partners in the effort to prevent all avoidable harm in healthcare. Risk and uncertainty are constant companions. So we come together in dialogue, participating in care with providers. We unite our strength as advocates for care without harm in the developing as well as the developed world.

We are committed to spread the word from person to person, town to town, country to country. There is a right to safe healthcare and we will not let the current culture of error and denial, continue. We call for honesty, openness and transparency. We will make the reduction of healthcare errors a basic human right that preserves life around the world.

We, Patients for Patient Safety, will be the voice for all people, but especially those who are now unheard. Together as partners, we will collaborate in:

- Devising and promoting programs for patient safety and patient empowerment.
- Developing and driving a constructive dialogue with all partners concerned with patient safety.
- Establishing systems for reporting and dealing with healthcare harm on a worldwide basis.
- Defining best practices in dealing with healthcare harm of all kinds and promoting those practices throughout the world.

In honor of those who have died, those left disabled, our loved ones today and the world's children yet to be born, we will strive for excellence, so that all involved in healthcare are as safe as possible as soon as possible. This is our pledge of partnership.

March 29, 2006

- ❑ Established: 2005
- ❑ Objectives
  - Empower patients, families and communities to play an active role in their own care;
  - Bring the voices of patients and people to the forefront of health care;
  - Create an enabling environment for partnerships between patients, families, communities and health professionals

PFPS Network and Advisory Group

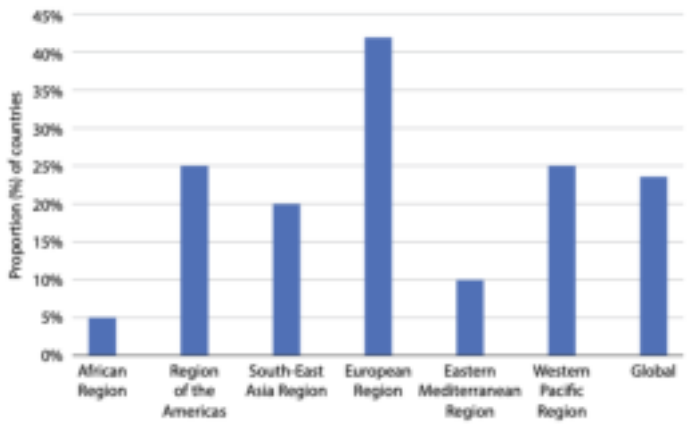
CORE Indicator

13%

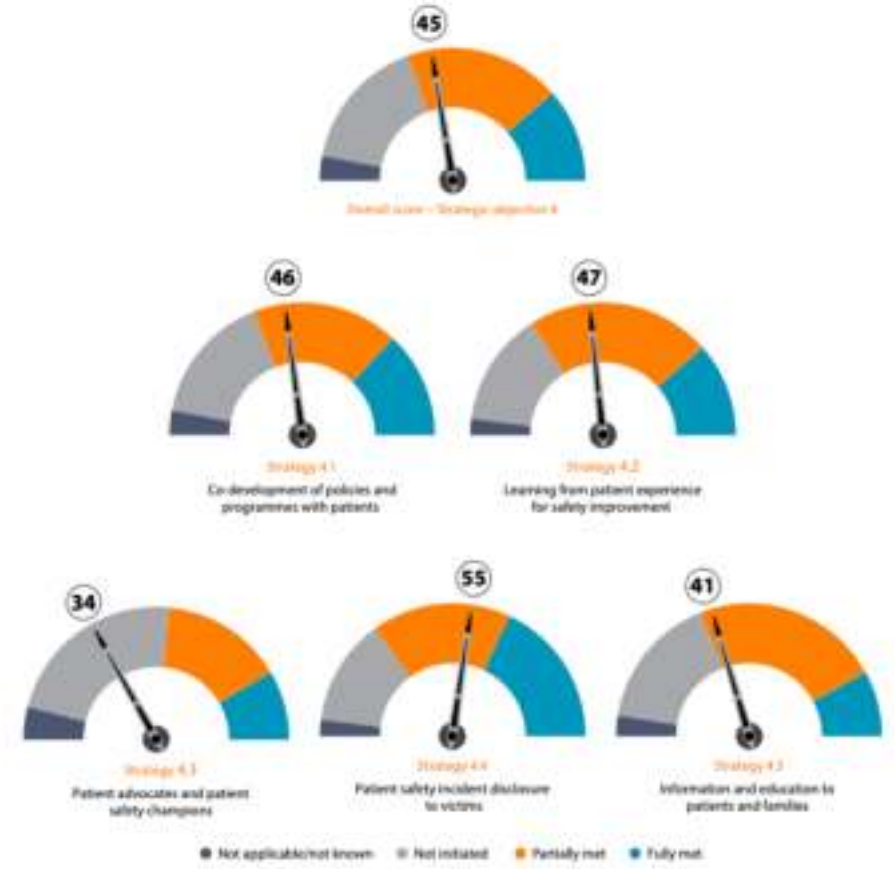
countries have appointed a patient representative to the governing board in of majority of hospitals

24%

countries have established procedures for disclosing adverse events to patients and families



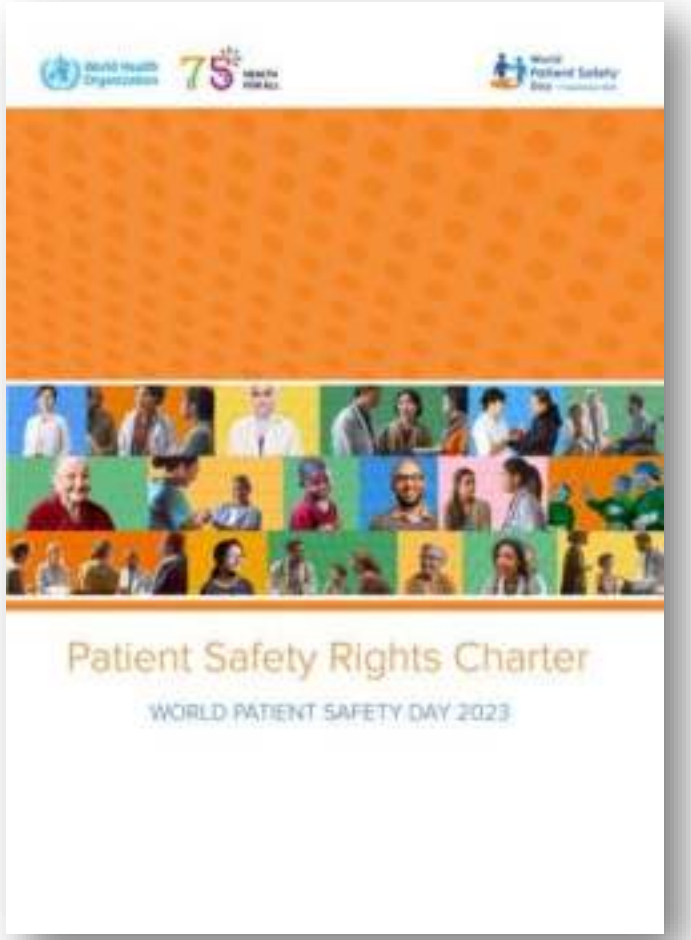
"We need to bridge the gap between intentions and real implementation of patient engagement "



Key findings

- 44% countries have established a patient right charter
- Only 20% codevelop polices with involvement of patients
- Only 10% countries have patient for patient safety networks
- 50% countries have procedures for accessing medical records
- Only 13% countries have initiatives to educate patients for their engagement

Co-development of policies and programmes

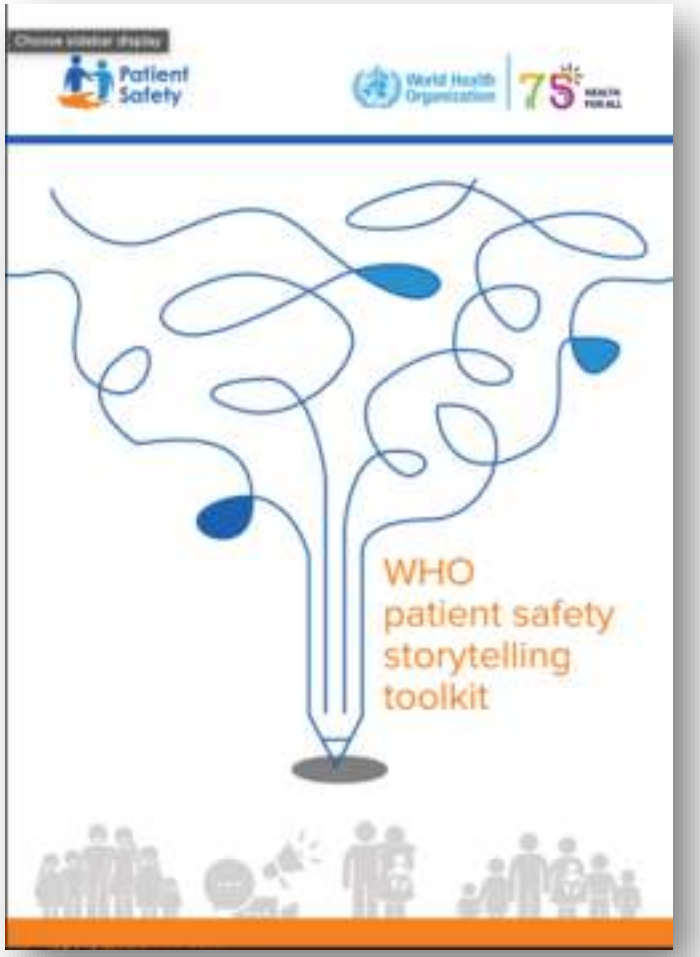


10 Patient safety rights

1. Right to timely, effective and appropriate care
2. Right to safe health care processes and practices
3. Right to qualified and competent health workers
4. Right to safe medical products and their safe and rational use
5. Right to safe and secure health care facilities
6. Right to dignity, respect, non-discrimination, privacy and confidentiality
7. Right to information, education and supported decision making
8. Right to access to medical records
9. Right to be heard and fair resolution
10. Right to patient and family engagement

Access to medical records

Recognition and capacity building of patient advocates



Patient organizations (IAPO, WPA, PFPS US, PFPS Canada, PFPS, Malaysia, PFPS Ireland)

Information and education to patients and families

In it together

Patient Safety

1. **Patients, families and caregivers**

Be informed, involved, and proactive in your diagnosis

- Be actively engaged in the diagnostic process and with your health care team:
  - share accurate and comprehensive information about your symptoms and medical history;
  - make sure you understand the diagnostic process, your illness' or symptoms expected progression, and next steps;
  - check your information is up-to-date, and keep track of your symptoms, medical visits, tests and treatments.
- Share your questions and concerns:
  - don't be afraid to ask questions;
  - speak up, ask about alternative options or seek a second opinion if you need to;
  - share your experiences and contribute to making diagnosis safer for others.

Learning from patient stories

- ❑Patient stories
- ❑Video testimonies (WPSD, PFPS and WHO Academy) - Happening today

29 August 2017

Medication Without Harm: Real-life stories

Stories from health care workers

31 May 2017

Medication Without Harm: Real-life stories

Patient stories of harm

31 May 2017

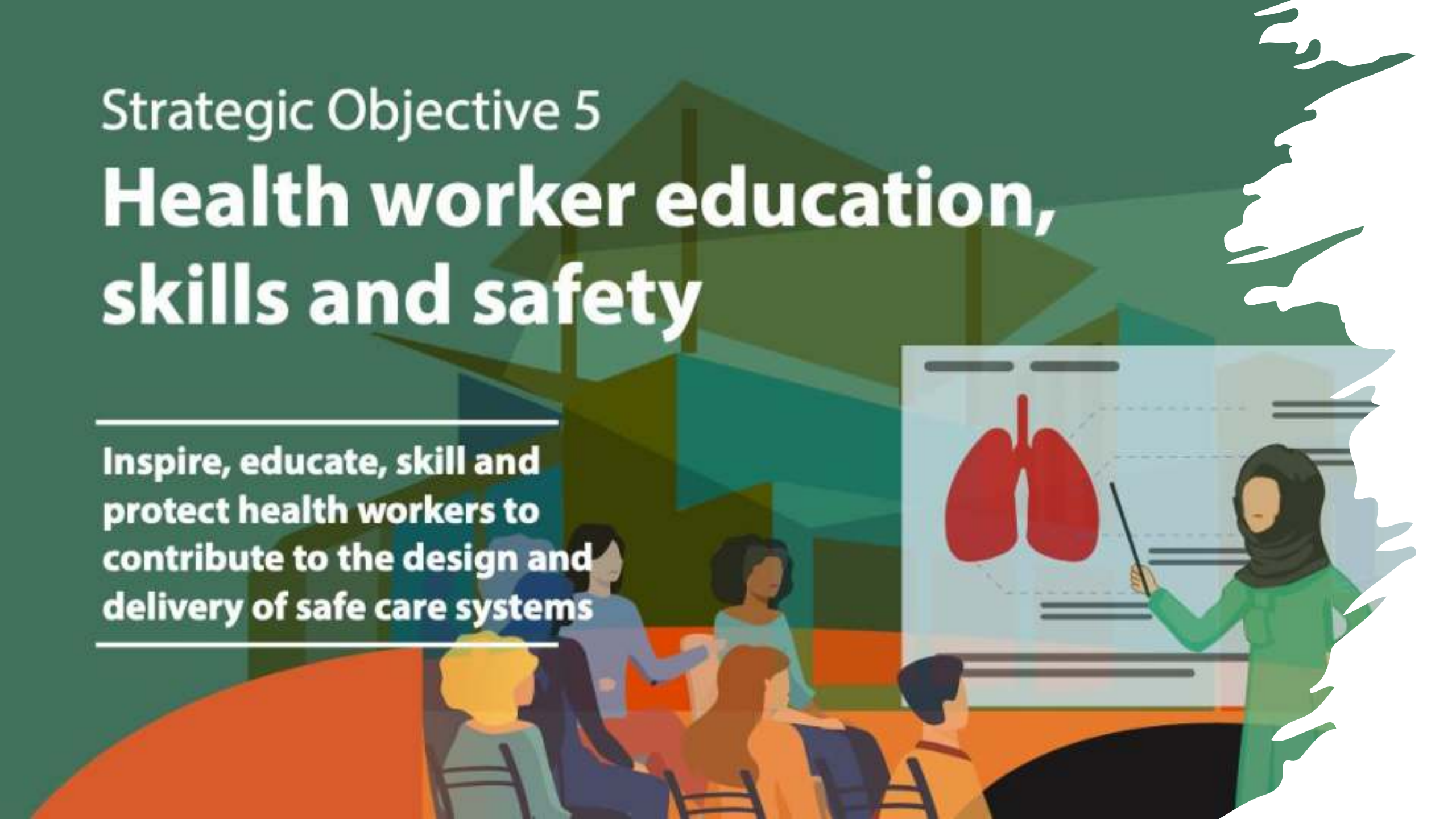
Medication Without Harm: Real-life stories

How patients and families have brought about change

Strategic Objective 5

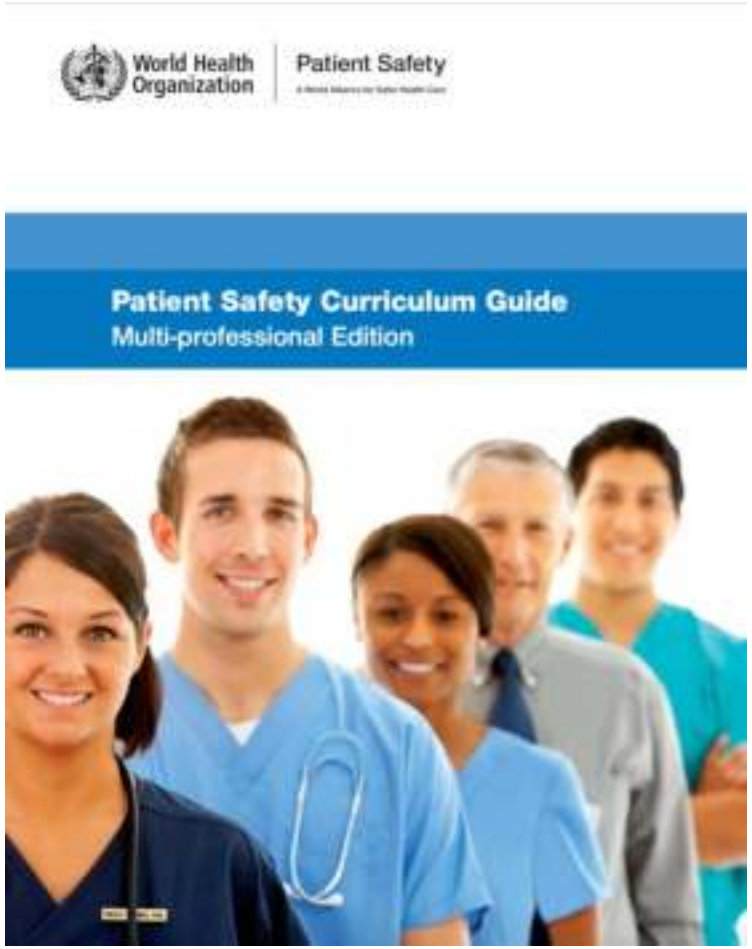
Health worker education, skills and safety

Inspire, educate, skill and protect health workers to contribute to the design and delivery of safe care systems



Education and Training

- Patient Safety Essentials Curriculum Guide
- Medication Safety Curriculum Guide
- Global Patient Safety Collaborative country support



In service training

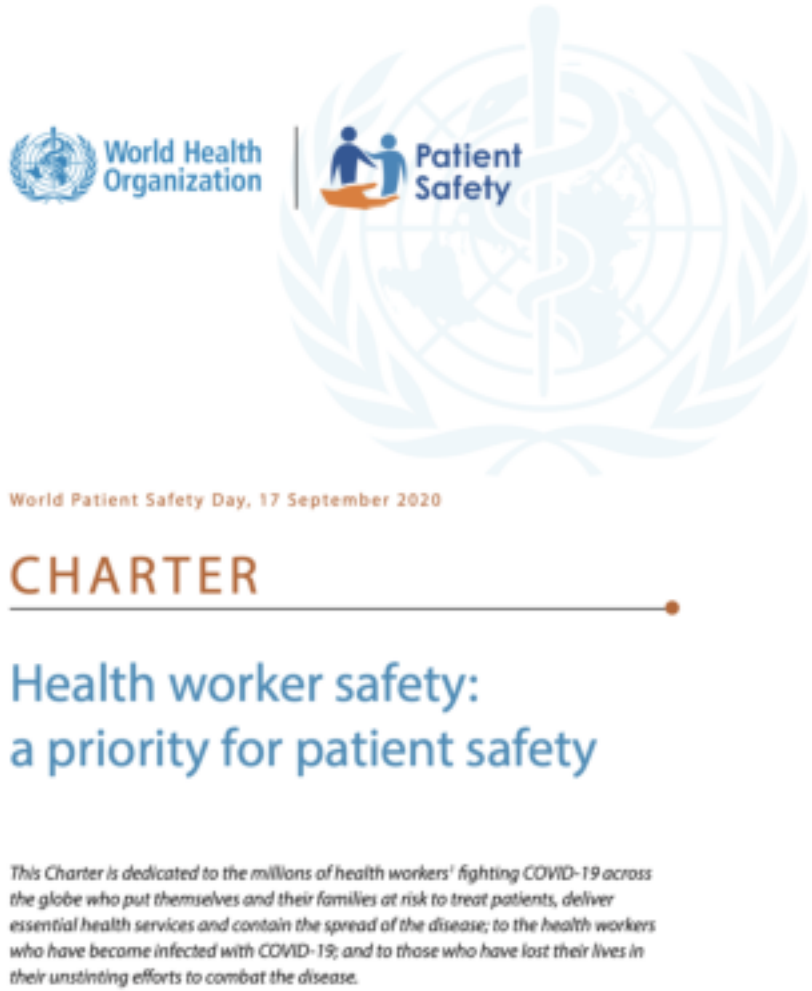
WHO Academy Patient Safety Essentials Course

- Module 1: Basic patient safety concepts, principles and definitions
- Module 2: System elements and systemic processes and approaches (including tools and methods) to ensure patient safety improvements
- Module 3: Patient Safety Navigator, practical application of tools to range of clinical areas

Safe working environment

WHO Health worker safety charter

- Calls on governments to take five actions
  - Better protect health workers from violence
  - Improve their mental health
  - Protect them from physical and biological hazards
  - Advance national programmes for health worker safety
  - Connect health worker safety policies to existing patient safety policies and strategies



20%

CORE Indicator

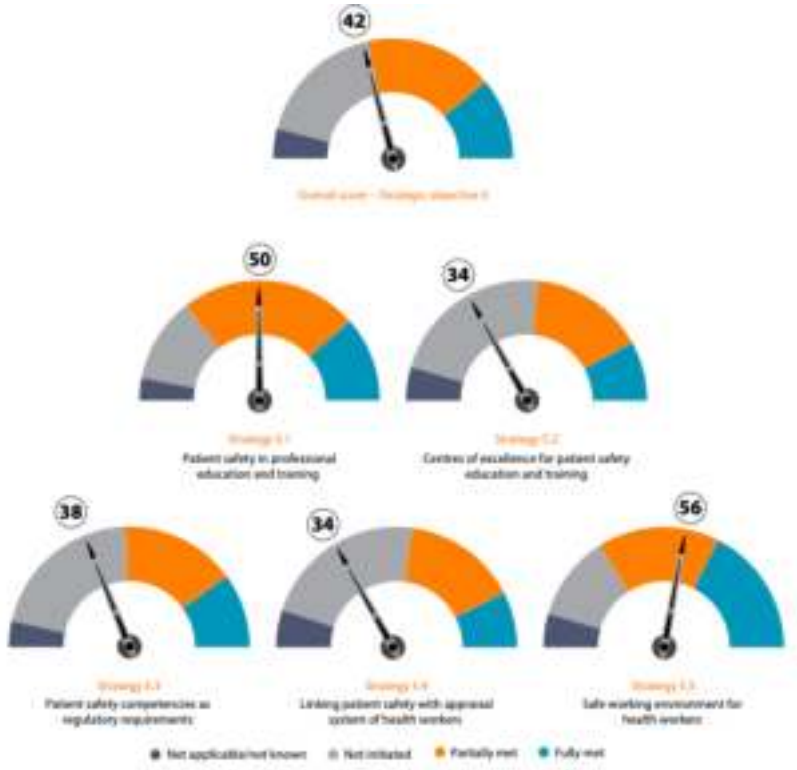
countries that have incorporated a patient safety curriculum in education programmes for health care professionals

18%

CORE Indicator

countries that have signed up for implementation of the WHO Health Worker Safety Charter

"We need significant investment and role models for patient safety education and training"



Key findings

- Only 17% countries have adopted WHO patient safety curriculum
- Only 10% countries have adequate trainers for patient safety
- 25% countries have defined patient safety core competencies
- 12% countries incentivize patient safety performance
- 55% countries provide vaccination of all at risk health workers

Strategic Objective 6

Information, research and risk management

Ensure a constant flow of information and knowledge to drive the mitigation of risk, a reduction in levels of avoidable harm, and improvements in the safety of care

World Health Organization

Member State survey on implementation of the Global Patient Safety Action Plan 2021–2030

Language: English - English

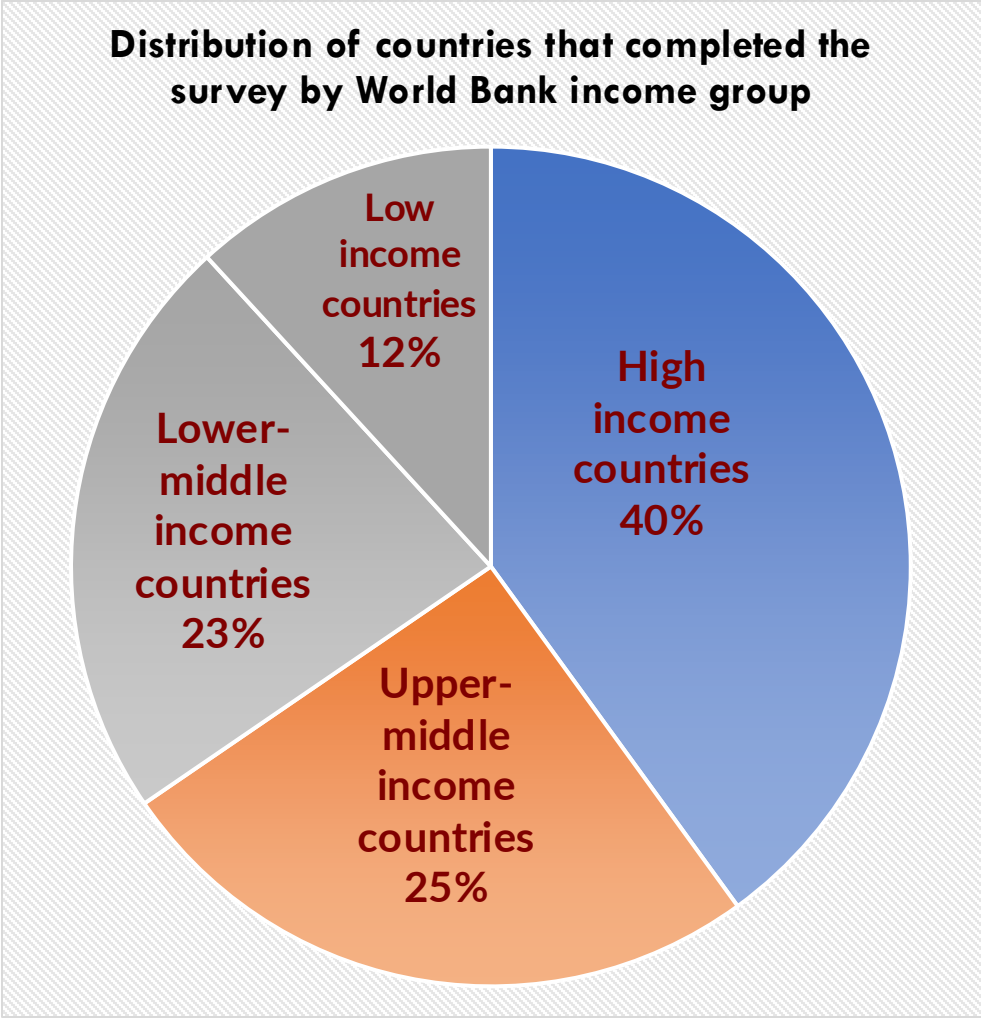
Respondent information

Details of the focal point(s) who provided the responses.

* Name

* Position / Designation

Response Characteristics



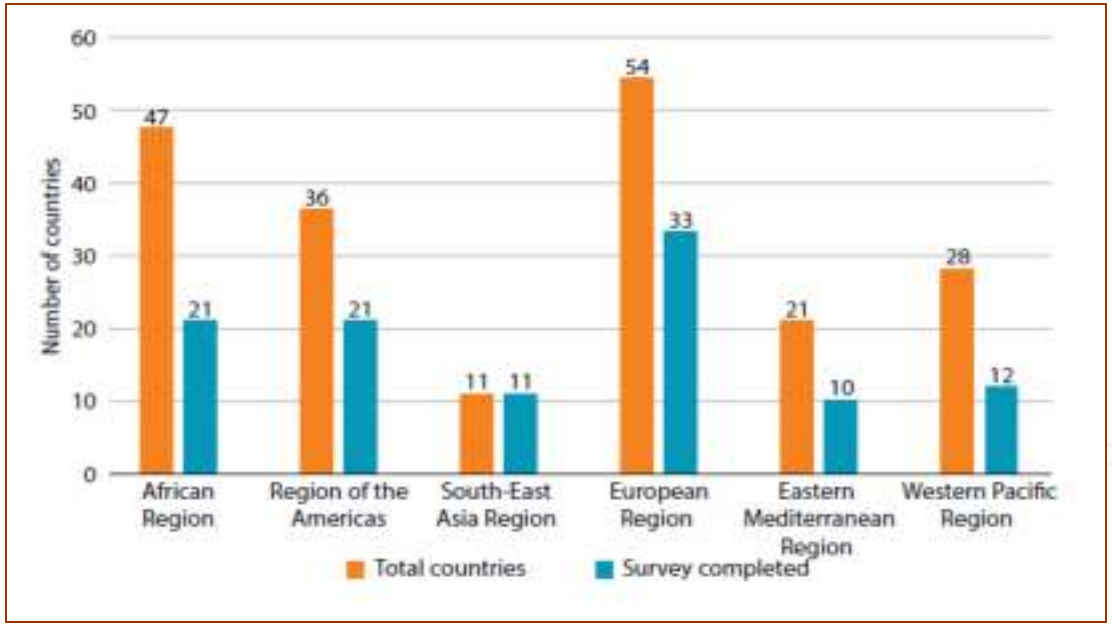
108 Countries responded officially through MOH

84% of world's population covered

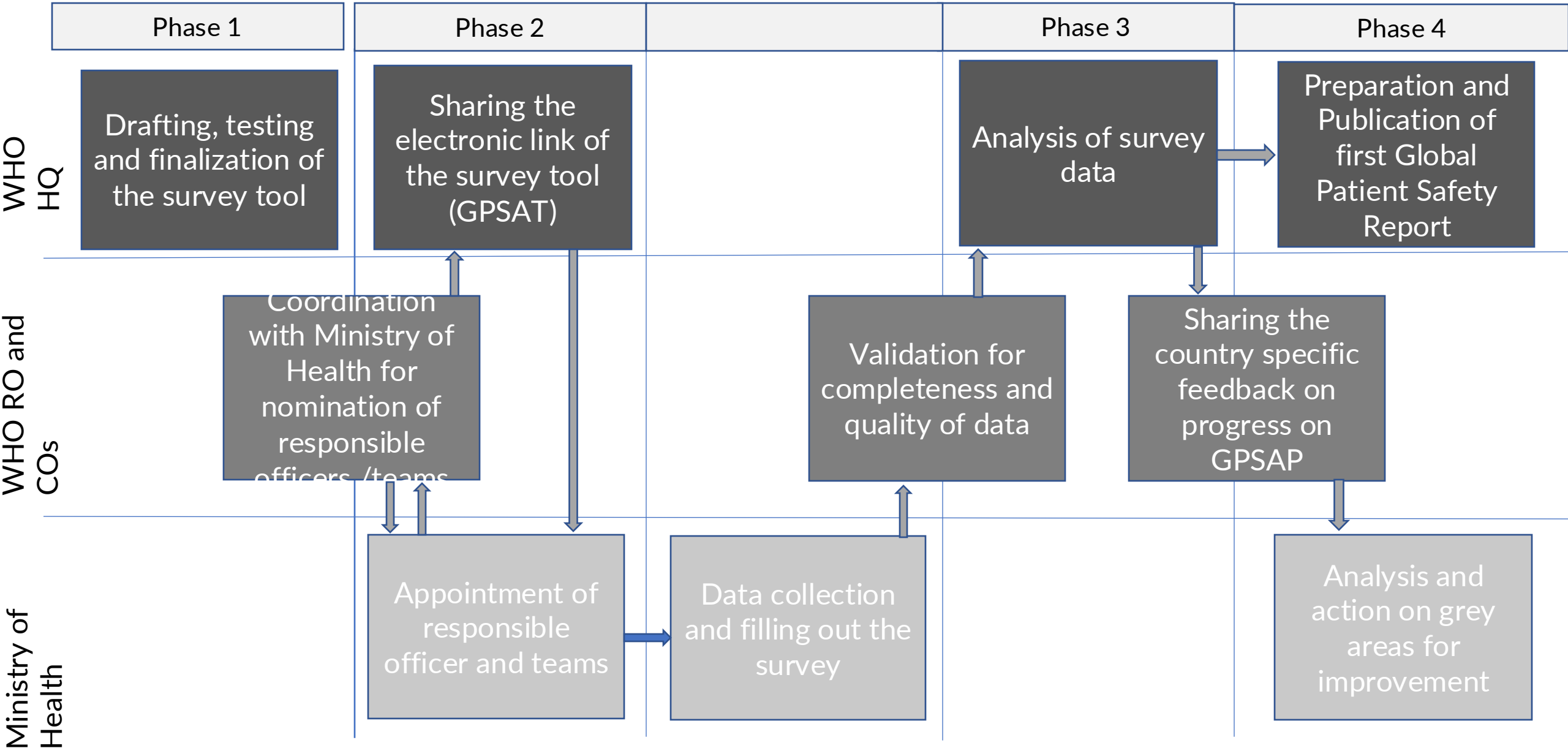
10 Core Indicators

7x5=35 Strategies

7x5x5=175 Criteria



Overview of the Member State survey process



Patient Safety

World Health Organization

Global patient safety report 2024

Global Patient Safety Observatory


WHO / Pallava Bagla

Patient safety is one of the most foundational and fundamental principles of medicine, essential for every country's journey towards universal health coverage and other health targets of the Sustainable Development Goals.

WHA72.6 resolution on Global action on patient safety urges all Members States to recognize patient safety as a priority in all health sector policies and implement systemic measures to reduce risk of avoidable harm in health care and requests WHO to measure and report on the progress made by Member States in the implementation of the resolution. Further, WHA decision WHA74(13) adopted the Global Patient Safety Action Plan 2021-2030 requested the Director-General to report back on the implementation progress every two years. The plan provides a set of core and advanced indicators aligned with the strategic objectives to be measured.

In response to this mandate, the WHO secretariat conducted first Member State survey in 2022-2023 to measure progress in achieving the goals and strategic objectives of the Global Patient Safety Action Plan 2021-2030. The data was collected using the Global Patient Safety Assessment Tool. By May 2023, official responses were received from 108 Member States through a designated focal point responsible for patient safety in the country. This survey will be repeated very two.

The Global Patient Safety Observatory serves as a vital step forward in establishing a measurement agenda for patient safety globally. The trends and insights from this observatory will assist countries in making informed policy decisions and fostering data-driven improvements in patient safety.

Key figures

Burden of harm

Around 1 in every 10

patients is harmed in health care

Adverse events

134 million

adverse events occur in hospitals in LMICs

Global Progress

Overall 27%

of criteria were 'fully met' in the global survey

Patient Safety

World Health Organization

Patient safety country profile:

Greece

2024

Patient safety snapshot

Oman

Patient safety survey statistics	
Overall score (out of 100)	68.8
Criteria "Fully met"	90 (55%)
Criteria "Partially met"	14 (42%)
Criteria "Not initiated"	41 (25%)
Criteria "Not applicable"	7 (4%)
Survey completion	99%
SO1 Policies to eliminate avoidable harm in health care	
National patient safety action (or equivalent) plan	Partial
Financial resources for patient safety programme	Partial
Mandatory licensing of health care facilities	In place
Law(s) for authorization of use of medical products	In place
Regulation(s) for health data protection and confidentiality	Partial
Patient safety legislation	In place
Minimum safety standards	Partial
National campaign on World Patient Safety Day	In place
Implementation of Global Patient Safety Challenges	Partial
SO2 High-reliability systems	
System for reporting (near- (or sentinel) events	In place
No blame policy for reporting adverse events	In place
Organizational safety culture surveys	Partial
National patient safety officer	In place
Leadership capacity-building for patient safety	Partial
Human factors implementation to service delivery	Not initiated
Implementation of structural safety norms	Partial
Regular safety rehearsals (mock drills)	In place
SO3 Safety of clinical processes	
Identification of sources of significant patient harm	Partial
Focused patient safety improvement initiatives	In place
Initiatives on priority areas of medication safety[1]	In place
National targets for reducing medication-related harm	Not set
National targets for reducing HCAIs[2]	Not set
Surveillance system for infection prevention and control	In place
Pharmacovigilance system	Partial
Hemovigilance system	In place
Medical devices safety surveillance system	In place
Standard Operating Procedures for clinical handovers	In place
Diagnoses, treatment, and referral pathways	In place

SO4 Patient and family engagement	
Patient representation in hospital governing boards	Not initiated
National patient rights charter	Partial
Mechanisms on ease feedback from patients	Partial
Measuring patient-reported outcomes and experiences	Partial
Patients for patient safety network	Not initiated
Guidance for obtaining informed consent	In place
Patient's access to their medical records	Partial
Procedures to disclose adverse events to patients	Partial
Public information on quality and safety health services	Partial
SO5 Health worker education, skills and safety	
Patient safety included in health professional education	Partial
In-service training of health workers on patient safety	Partial
Institution(s) for patient safety education and training	Partial
Core competencies for patient safety have been defined	Not initiated
Core competence-driven licensing requirements	Not initiated
Appraisal on quality and patient safety performances	Not initiated
Endorsement of WHO Health worker safety charter	In place
Occupational health and safety programme	In place
Vaccination of health workers	In place
SO6 Information, research and risk management	
Entity for patient safety reporting and learning system	In place
Functionality of the reporting and learning system	In place
Regular alerts on patient safety risks and harm	In place
Patient safety indicators in health information system	Partial
Annual report on patient safety	In place
Investigation mechanism for serious safety events	In place
Patient safety research priorities	Partial
Safety assessment of health technologies	Partial
Implementation of electronic health records	No info
SO7 Synergy, partnership, and solidarity	
Stakeholder analysis for patient safety	Not initiated
Private sector and industry engagement	Partial
Patient safety goals and targets defined	In place
National patient safety network	Not initiated
Dissemination of best practices on patient safety	Not initiated
Participation in global ministerial summits	In place
Patient safety within the health system strengthening	In place

[1] Out of the 176 criteria from the global patient safety checklist survey, based on the Global patient safety action plan 2021–2030.

[2] Priority areas: polypharmacy; high-risk situations and transition of care; HCAI = health care-associated infection.

Overall scores: Strategic objectives 1–7

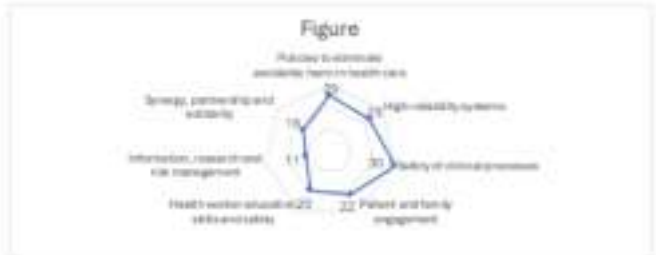
Scorecard		
Global median	Self-reported scores (as a percentage)	Global Q3 benchmark
48.0%	41.7%	58.3%
LMC median		WPR median
36.8%		58.8%

The national progress on strategic objectives is presented alongside aggregated scores on the global median, the median for countries within the same World Bank income group, the third quartile (highlighting the scores of countries in the top 25% of performers) and the WHO regional median. The performance scores should not be used to compare countries, as the survey was based on self-assessment and each country faces unique challenges in maintaining patient safety within its health care system. Instead, these scores should be viewed as a source of inspiration for improvement.

Country scores across the strategic objectives of the Global Patient Safety Action Plan 2021–2030		
	Strategic objective	Score/50
1	Policies to eliminate avoidable harm in health care	25
2	High-reliability systems	33
3	Safety of clinical processes	30
4	Patient and family engagement	22
5	Health worker education, skills and safety	20
6	Information, research and risk management	11
7	Synergy, partnership and solidarity	15
Total obtained score		146/350

Each strategic objective consists of five strategies, with a total of 25 criteria. For each criterion, a score is assigned: two points for "fully met," one point for "partially met", and zero points for "not met." Criteria marked as "not applicable" are excluded from the scoring. Thus, the maximum possible score for each strategic objective is 50. A visual presentation of the performance across the strategic objectives is presented below.

Figure



Ongoing patient safety measurement work

- Patient safety Member State Survey 2.0
- WHO Medication safety assessment tool
- WHO Patient safety assessment tool for health care facilities
- Global patient safety report 2025
- Patient safety outcome indicators
- Capacity building on Patient safety incident reporting and learnings systems

Patient Safety Incident Reporting and Learning Systems

- Technical Guidance
- Minimum information model
- Taxonomy and classification of patient safety incidents
- Country capacity building

32%

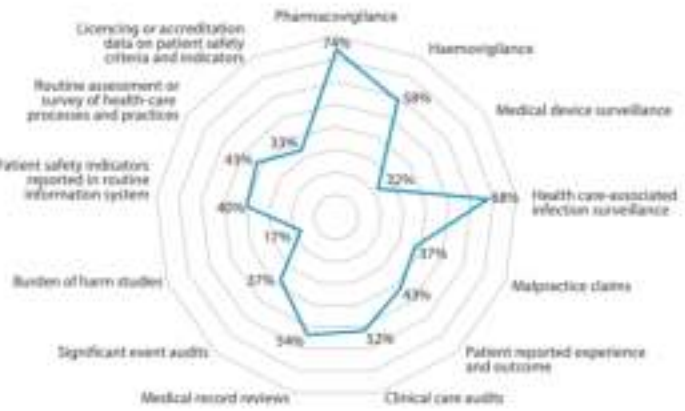
CORE Indicator

countries have majority of health care facilities participating in a patient safety incident reporting and learning system

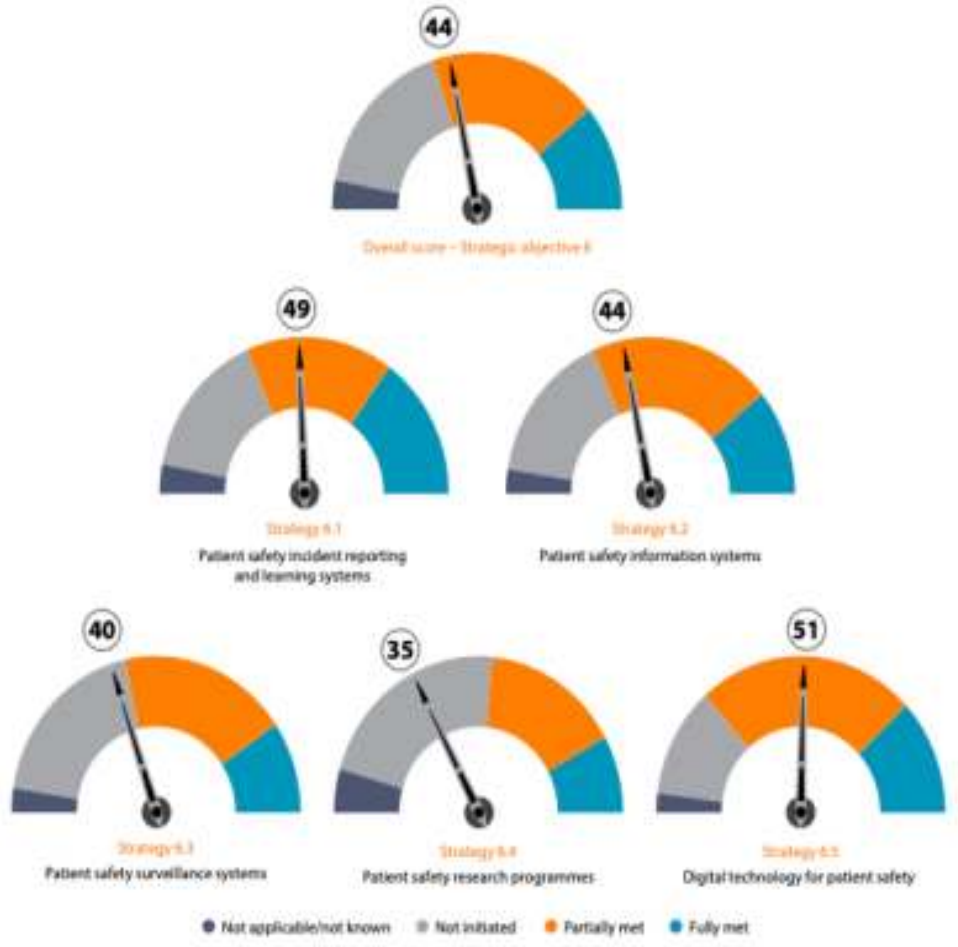
18%

CORE Indicator

countries publish an annual report on patient safety



"In the coming years we should focus on 'learning' form patient safety data"



Key findings

- 30% countries have designated a national institution for PS-RLS
- 25% countries have incorporated patient safety indicators in HMIS
- Only 13% countries have conducted studies on burden of harm
- Only 11% countries have integrated various safety surveillance systems
- Only 6% countries provide funds for patient safety research

Strategic Objective 7

Synergy, partnership and solidarity

Develop and sustain multisectoral and multinational synergy, partnership and solidarity to improve patient safety and quality of care

Strategic Objective 2: Key implementation areas

- **Stakeholder engagement:** different mechanisms for engagement, such as NSAs in official relations, WHO Collaborating Centres, MoU-based collaborations
- **Common understanding and shared commitment:**
- **Patient safety networks and collaboration:** Global Patient Safety Network, Global Knowledge Sharing Platform
- **Cross-geographical and multi-sectoral initiatives for patient safety:** Global Ministerial Summits on Patient Safety, Global Patient Safety Collaborative
- **Alignment with technical programmes and initiatives:** QoC, IPC, AMR, disease-specific programmes

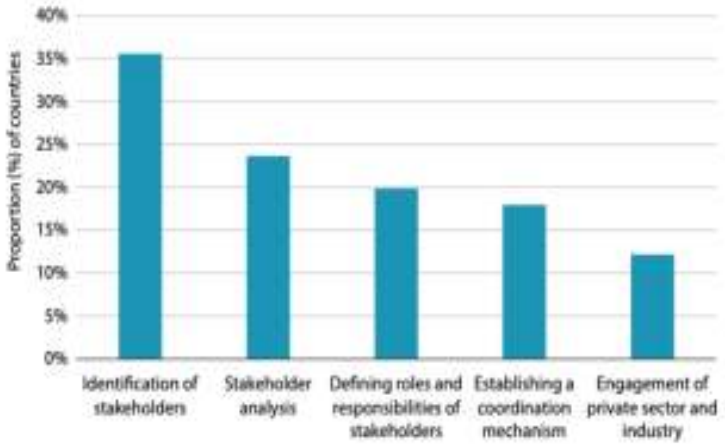
CORE Indicator

21%

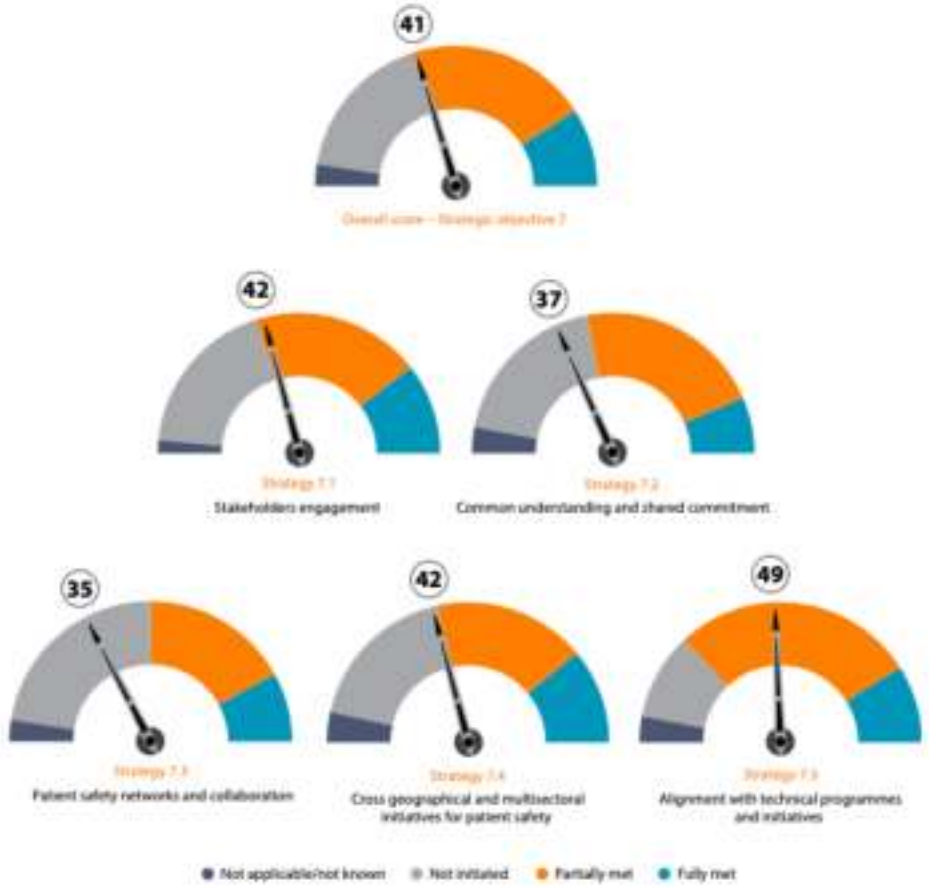
Countries established a national patient safety network

80%

Countries have made efforts to integrate patient safety with other health system strengthening efforts



"International collaborations have paid its dividend in global patient safety movement. We need to replicate and integrate efforts at national and sub national level."



Key findings

- 65% countries have initiatives for engaging private sector in patient safety
- 17% countries have established coordination mechanism for various stakeholders
- 20% countries have established national goals and targets for patient safety
- 28% countries share best practices
- 73% countries participate in global ministerial summits






Patient Safety Flagship

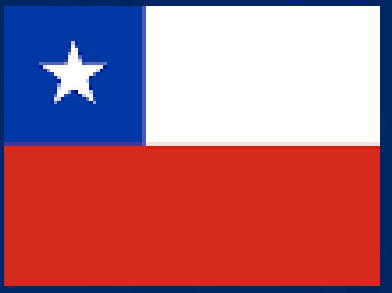
World Patient Safety Day 17 September 2024

World Health Organization

Thank you

Country stories

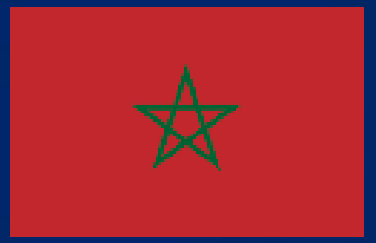
Moderator
Sir Liam DONALDSON
WHO Envoy for
Patient Safety



Policy development:
Malta

Legislation and patient and family engagement:
Sri Lanka

Point of care improvement programs:
Cambodia



Incident reporting and learning systems:
Morocco

Partnerships:
Chile and the
Philippines

World Health Organization

World Patient Safety Day 17 September 2024

World Patient Safety Day 2024

WHO Global Consultation

Improving diagnostic safety and implementing the Global Patient Safety Action Plan 2021-2030

10th – 12th September 2024
Geneva, Switzerland

World Health Organization

World Patient Safety Day 17 September 2024

Session 5
Mechanisms for implementing GPSAP 2021-2030

Chairperson
Neelam DHINGRA
Vice President, Chief Patient Safety Officer
Joint Commission International
Switzerland

Co-chairperson
Dr Giulia DAGLIANA
Coordinator, Centre for Clinical Risk Management and Patient Safety
Italy

World Health Organization

World Patient Safety Day 17 September 2024

Panel discussion
Challenges and opportunities at regional level

Dr Nurshaim TILENBAEVA WHO Regional office for Europe

Dr Mondher LETAIEF, WHO regional Office for Eastern Mediterranean Region

Dr Aparna SINGH SHAH WHO Regional Office for South East Asian Region

Ogusa SHIBATA WHO Regional Office for Western Pacific Region

Dr Pierre KARIYO, WHO Regional Office for African Region

Dr Blanca PENALOZA, WHO Regional Office for the Americas

World Health Organization

World Patient Safety Day 17 September 2024

Global Patient Safety Action Plan 2021-2030 implementation: recalibrating the compass

Dr. Nikhil GUPTA
Technical officer,
Patient Safety Flagship
Integrated Health Services,
WHO Headquarters
Switzerland

World Health Organization

World Patient Safety Day 17 September 2024

World Patient Safety Day 17 September 2024

World Health Organization

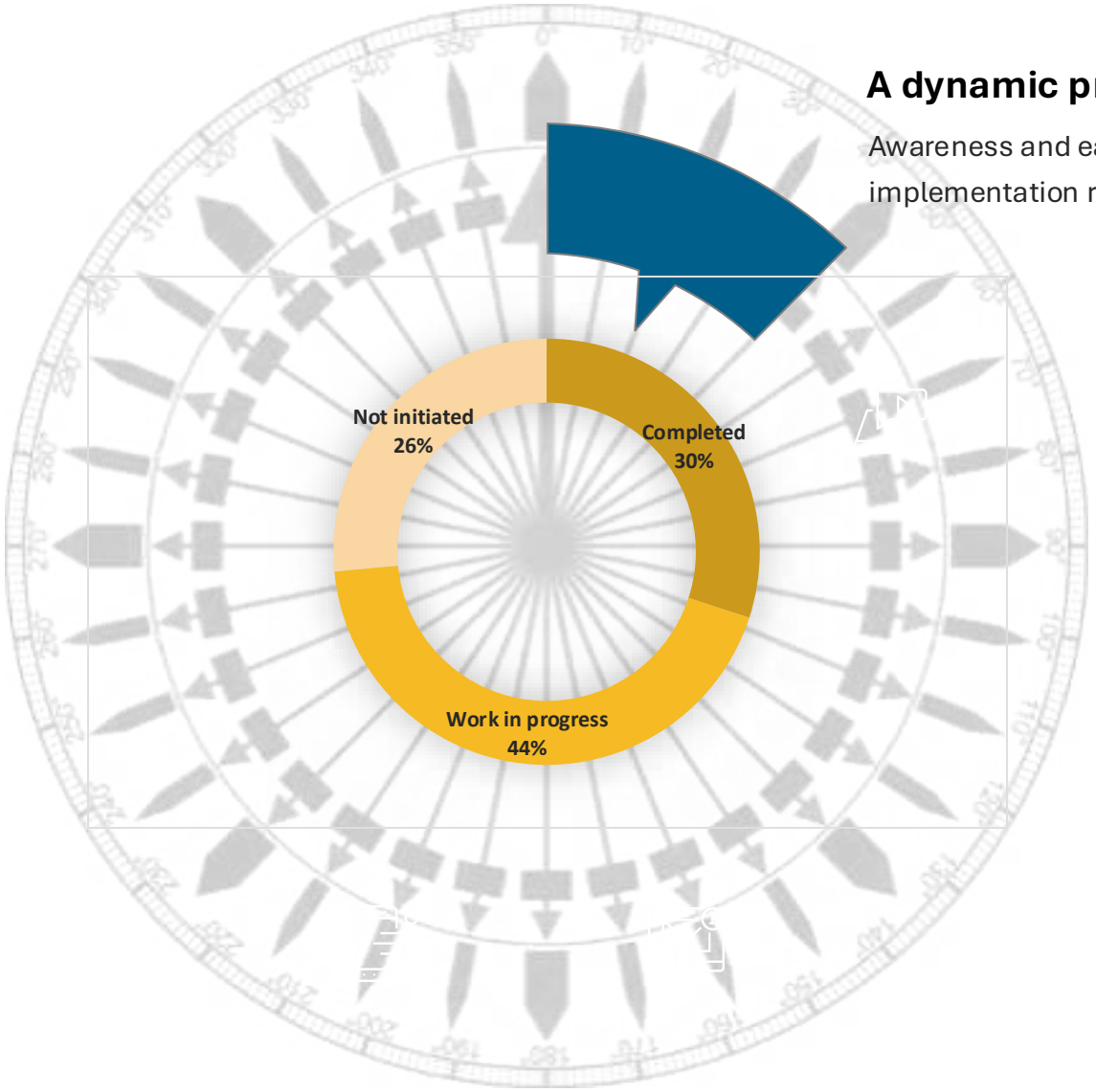
Global Patient Safety Action Plan Implementation

Recalibrating the compass

Nikhil Prakash Gupta
Technical Officer
Patient Safety Flagship

World Patient Safety Day 17 September 2024

World Health Organization



A dynamic process in motion

Awareness and early initiation exist, but implementation requires focused effort

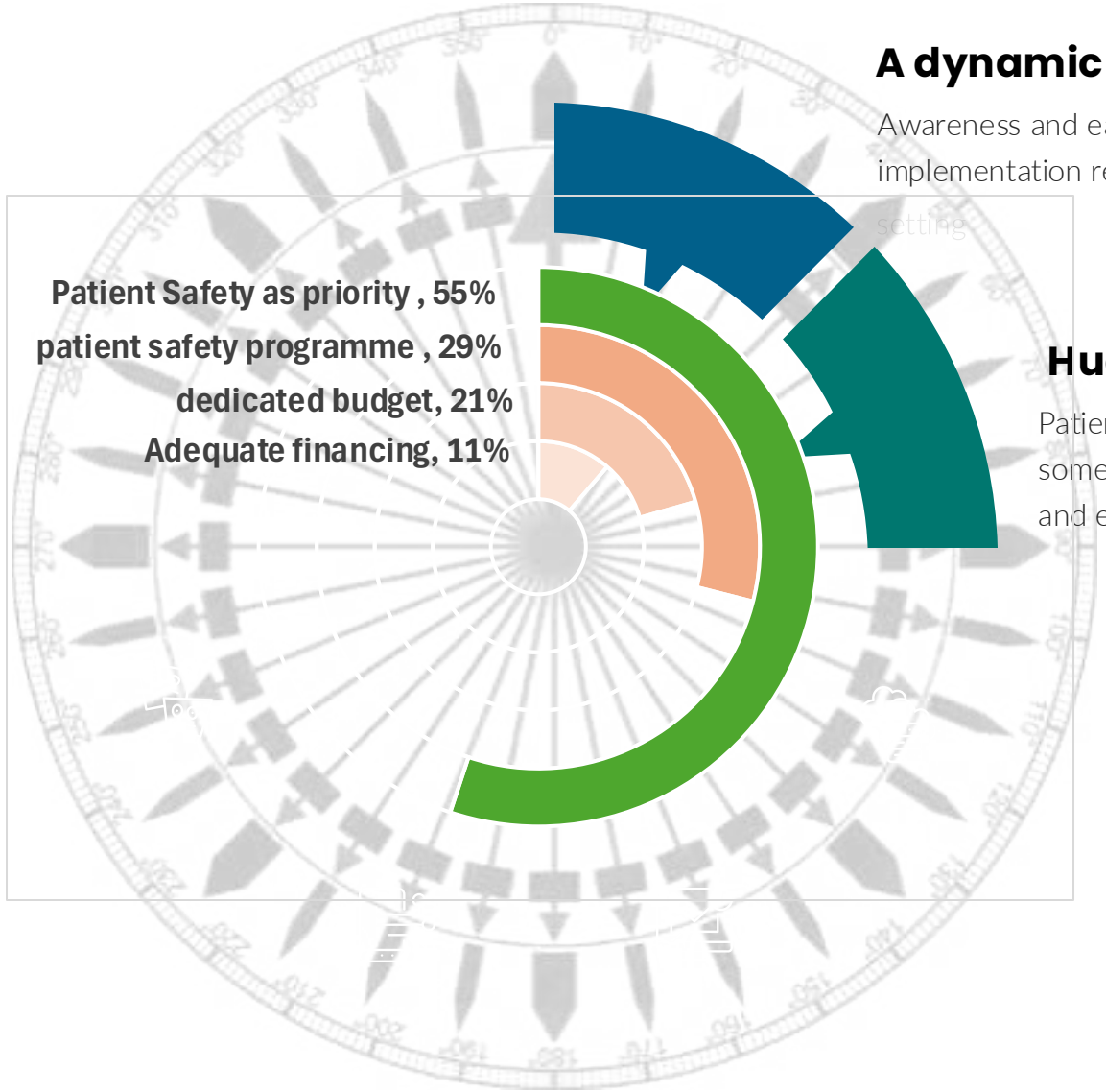
World Patient Safety Day 17 September 2024

World Health Organization

A dynamic process in motion

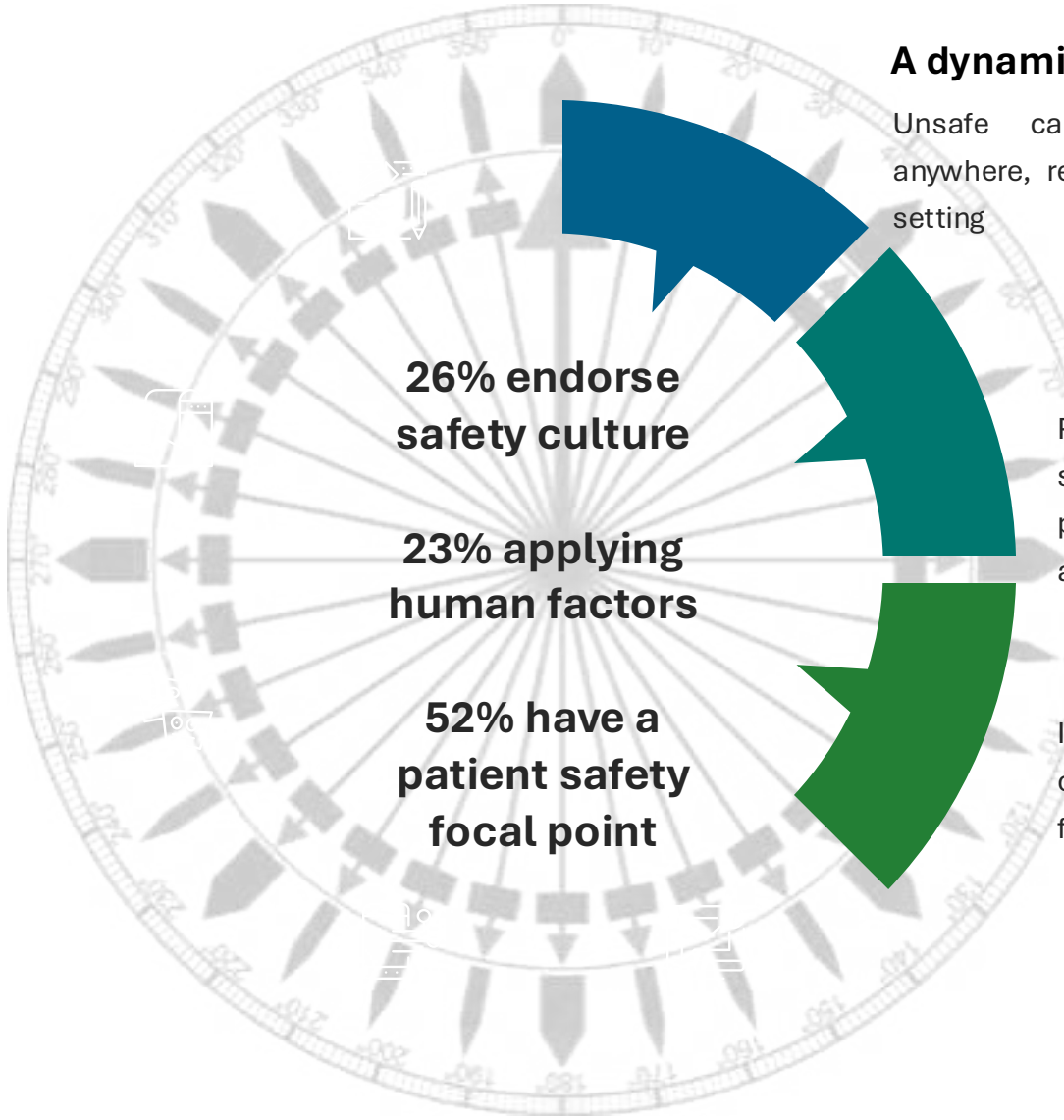
Awareness and early initiation exist, but implementation requires focused effort

setting



Huge potential, underfunded

Patient safety is a policy priority, but only some countries have structured programs, and even fewer provide adequate funding



A dynamic process in motion

Unsafe care can impact anyone, anywhere, regardless of income or care setting

Huge potential, underfunded

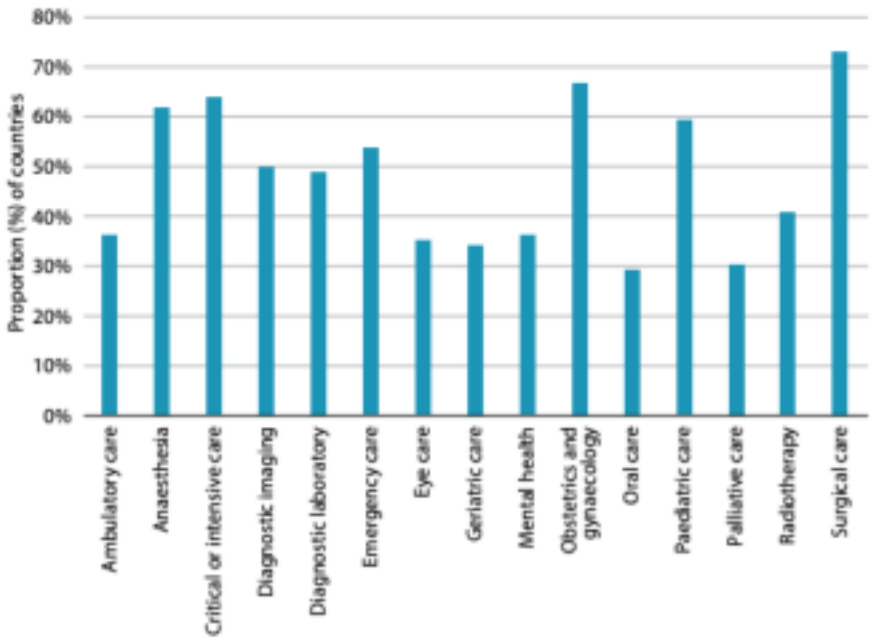
Patient safety is a policy priority, but only some countries have structured programs, and even fewer provide adequate funding

Systems approach

Increasingly, countries recognize the value of embedding a safety culture and human factors to enhance healthcare safety

World Patient Safety Day 17 September 2024

World Health Organization



A dynamic process in motion

Unsafe care can impact anyone, anywhere, regardless of income or care setting

Huge potential, underfunded

Patient safety is a policy priority, but only some countries have structured programs, and even fewer provide adequate funding

Systems approach

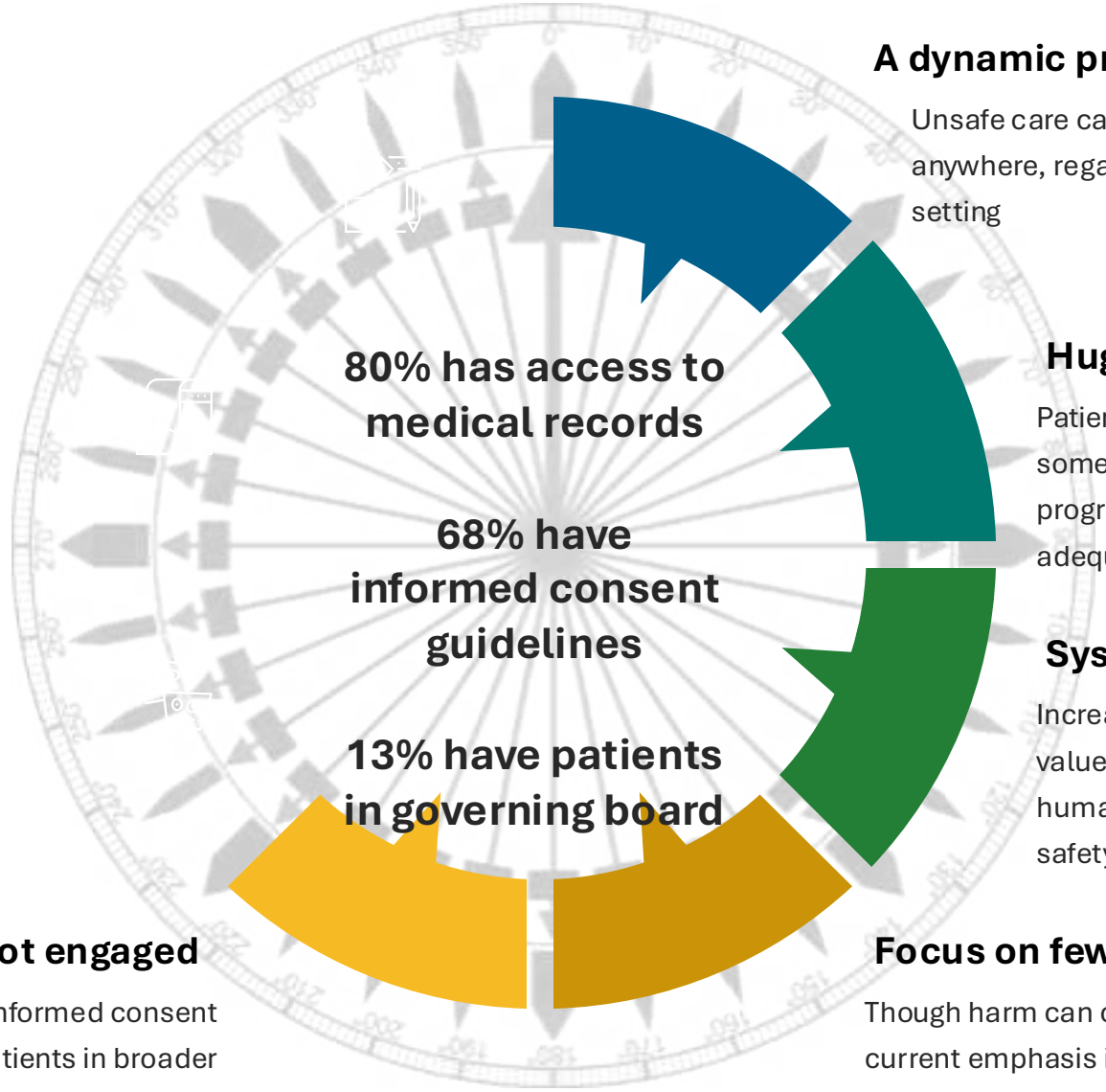
Increasingly, countries recognize the value of embedding a safety culture and human factors to enhance healthcare safety

Focus on few clinical disciplines

Though harm can occur in any setting, the current emphasis is on addressing high-risk procedures

World Patient Safety Day 17 September 2024

World Health Organization



A dynamic process in motion

Unsafe care can impact anyone, anywhere, regardless of income or care setting

Huge potential, underfunded

Patient safety is a policy priority, but only some countries have structured programs, and even fewer provide adequate funding

Systems approach

Increasingly, countries recognize the value of embedding a safety culture and human factors to enhance healthcare safety.

Patients are informed, not engaged

Access to medical records and informed consent is common, but fully engaging patients in broader healthcare delivery still needs significant work.

Focus on few clinical disciplines

Though harm can occur in any setting, the current emphasis is on addressing high-risk procedures

World Patient Safety Day 17 September 2024

World Health Organization

A dynamic process in motion

Unsafe care can impact anyone, anywhere, regardless of income or care setting

Huge potential, underfunded

Patient safety is a policy priority, but only some countries have structured programs, and even fewer provide adequate funding

Systems approach

Increasingly, countries recognize the value of embedding a safety culture and human factors to enhance healthcare safety.

Focus on few clinical disciplines

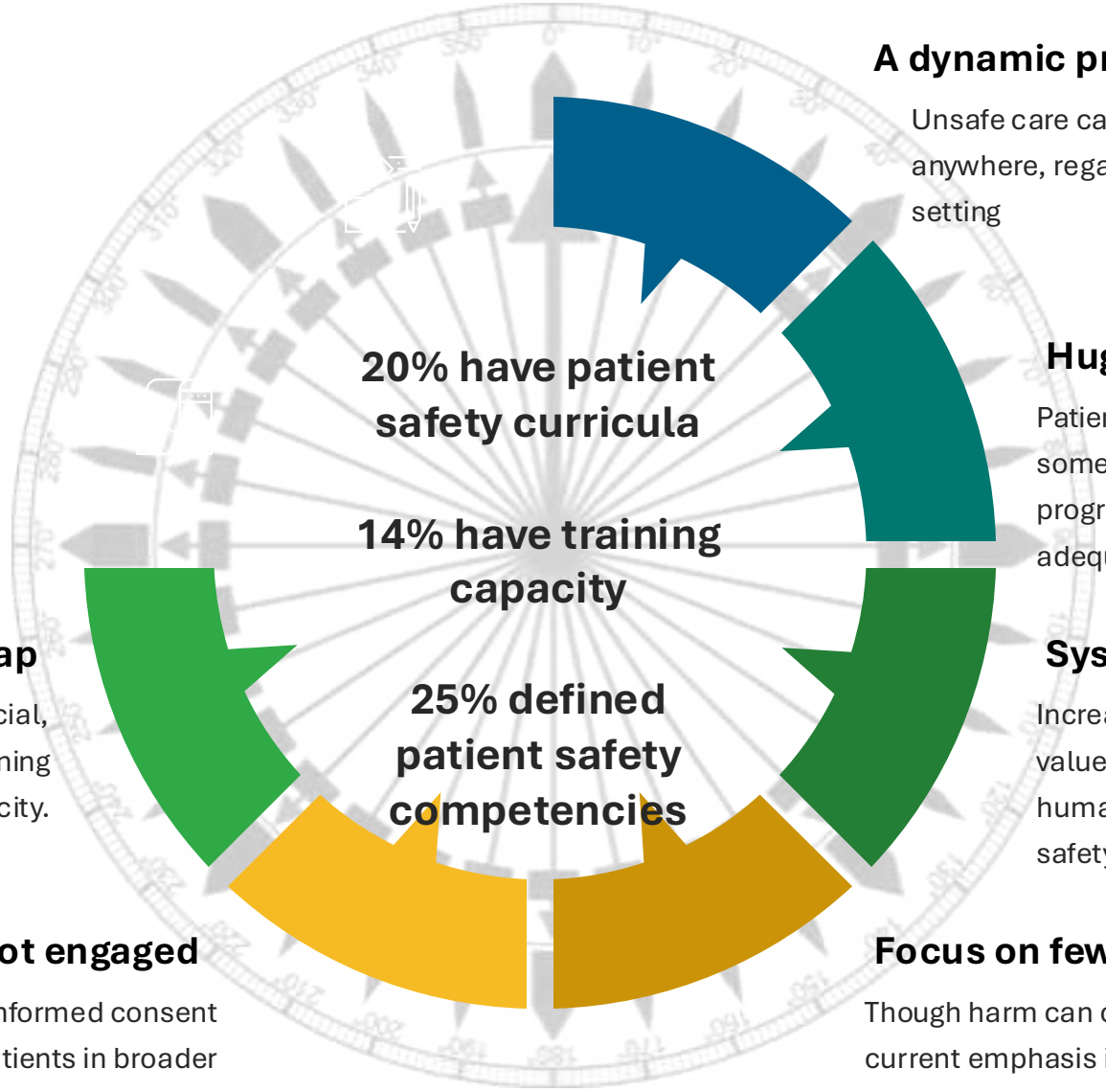
Though harm can occur in any setting, the current emphasis is on addressing high-risk procedures

Patients are informed, not engaged

Access to medical records and informed consent is common, but fully engaging patients in broader healthcare delivery still needs significant work.

Global skills gap

While patient safety education is crucial, there remains a substantial gap in training capacity.



World Patient Safety Day 17 September 2024

World Health Organization

A dynamic process in motion

Unsafe care can impact anyone, anywhere, regardless of income or care setting

Huge potential, underfunded

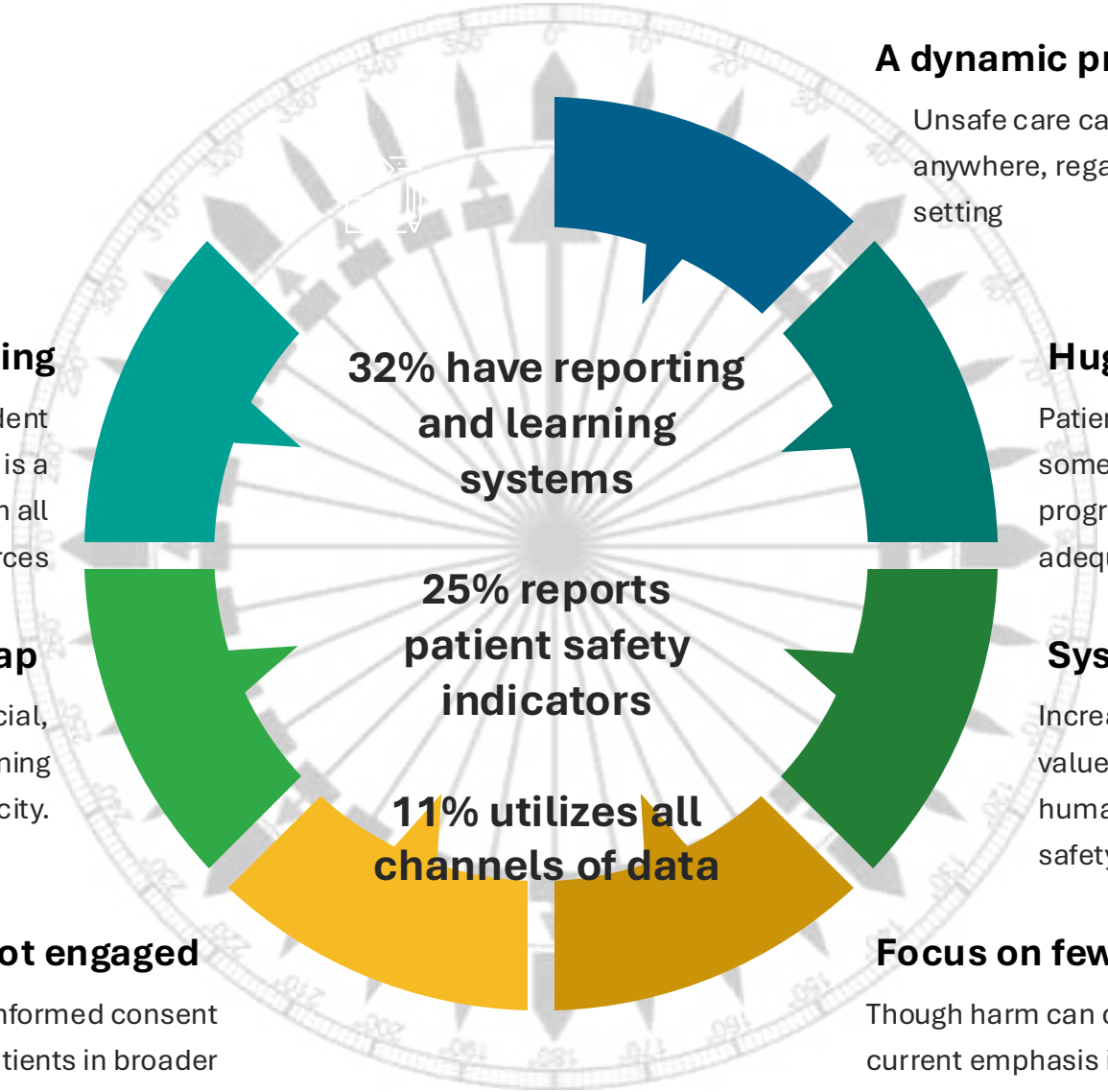
Patient safety is a policy priority, but only some countries have structured programs, and even fewer provide adequate funding

Systems approach

Increasingly, countries recognize the value of embedding a safety culture and human factors to enhance healthcare safety.

Focus on few clinical disciplines

Though harm can occur in any setting, the current emphasis is on addressing high-risk procedures



Evolving from reporting to learning

As the adoption of safety incident reporting systems increases, there is a need to leverage holistic learning from all data sources

Global skills gap

While patient safety education is crucial, there remains a substantial gap in training capacity.

Patients are informed, not engaged

Access to medical records and informed consent is common, but fully engaging patients in broader healthcare delivery still needs significant work.

World Patient Safety Day 17 September 2024

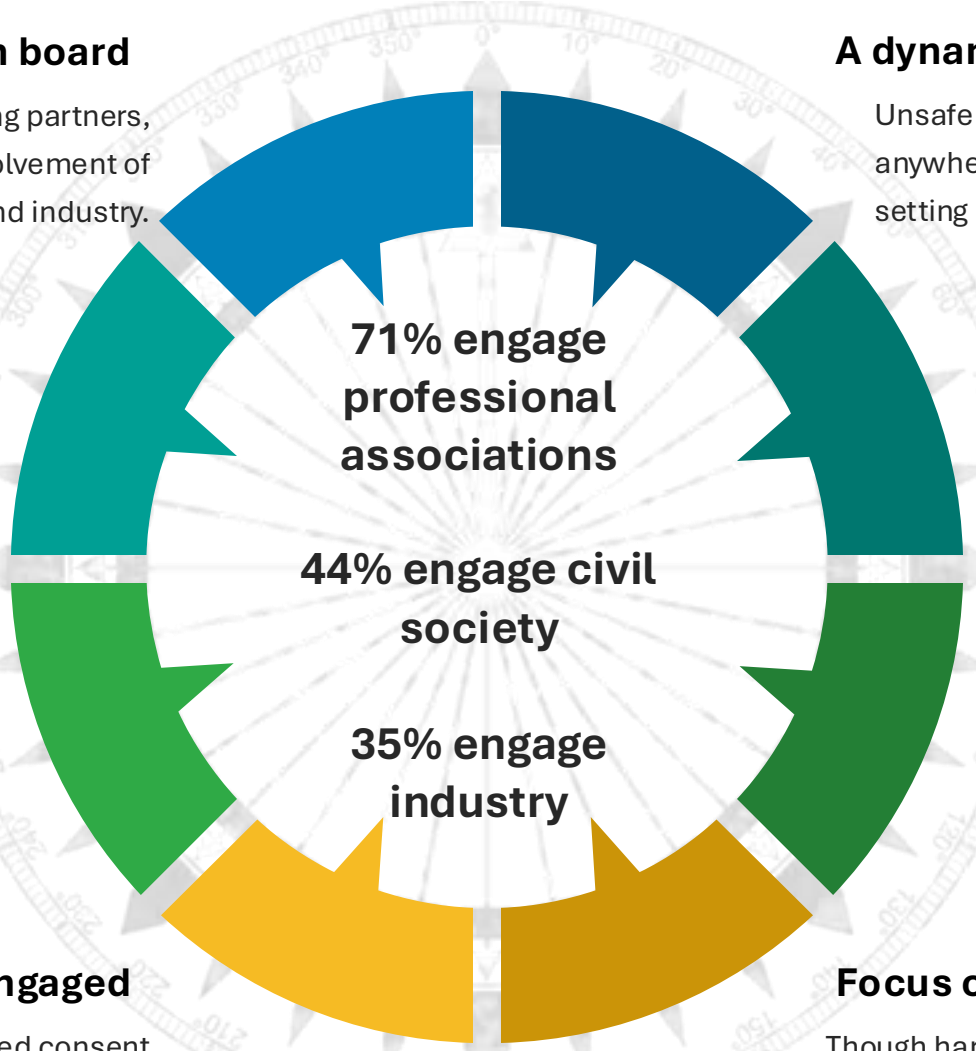
World Health Organization

Bringing all stakeholders on board

While countries are actively engaging partners, there is still potential for further involvement of the private sector and industry.

A dynamic process in motion

Unsafe care can impact anyone, anywhere, regardless of income or care setting



Evolving from reporting to learning

As the adoption of safety incident reporting systems increases, there is a need to leverage holistic learning from all data sources

Huge potential, underfunded

Patient safety is a policy priority, but only some countries have structured programs, and even fewer provide adequate funding

Global skills gap

While patient safety education is crucial, there remains a substantial gap in training capacity.

Systems approach

Increasingly, countries recognize the value of embedding a safety culture and human factors to enhance healthcare safety.

Patients are informed, not engaged

Access to medical records and informed consent is common, but fully engaging patients in broader healthcare delivery still needs significant work.

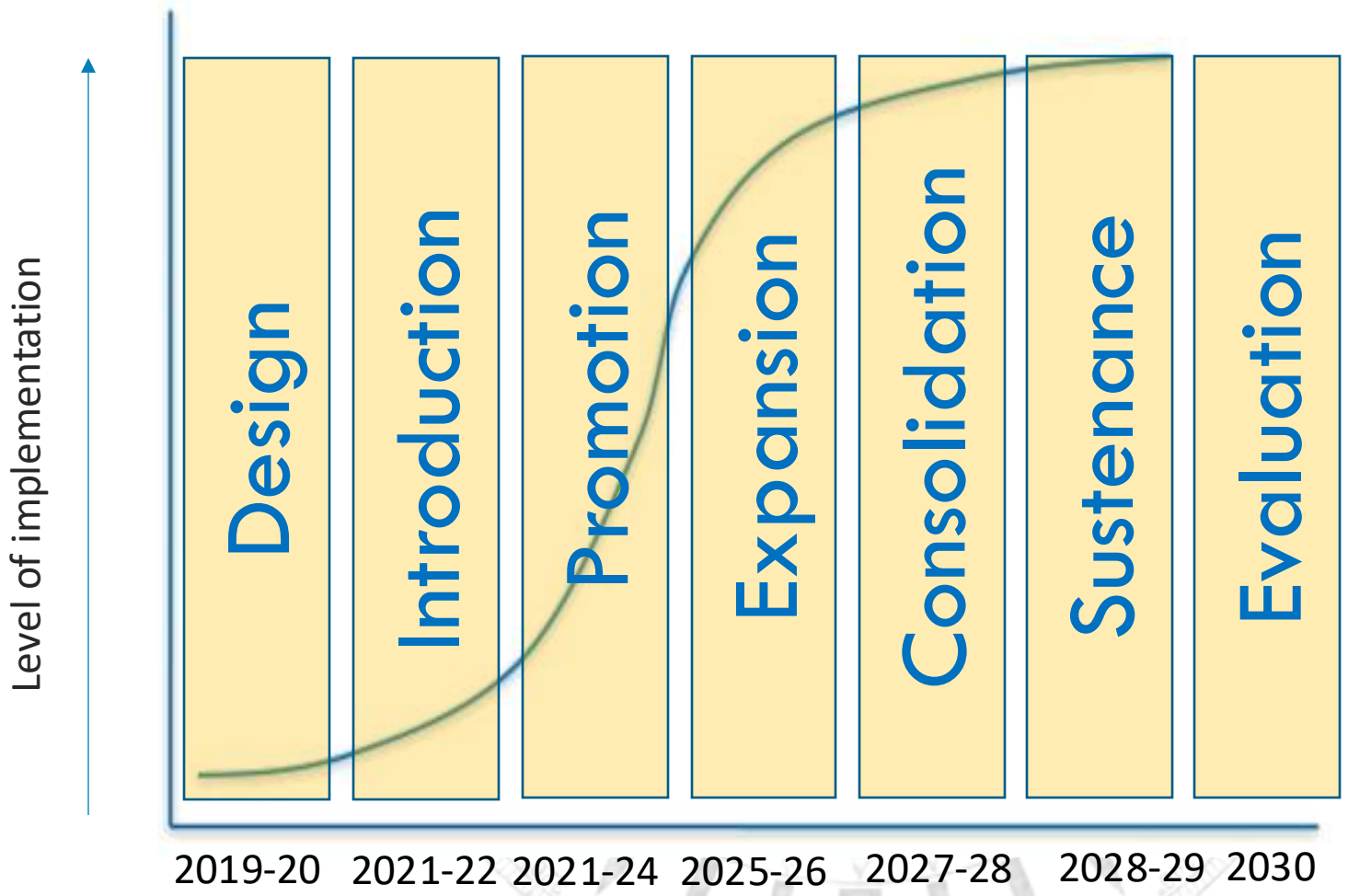
Focus on few clinical disciplines

Though harm can occur in any setting, the current emphasis is on addressing high-risk procedures

World Patient Safety Day 17 September 2024

World Health Organization

Life cycle of the action plan



World Patient Safety Day 17 September 2024

World Health Organization

Thank you

Introduction to group work

Alexandra Shaw
WHO Consultant
Patient Safety Flagship
Integrated Health Services
WHO Headquarters
Switzerland

World Health Organization

World Patient Safety Day 17 September 2024

Objective

Develop a driver diagram to identify the specific actions which can be taken to develop a high-reliability system for safer care

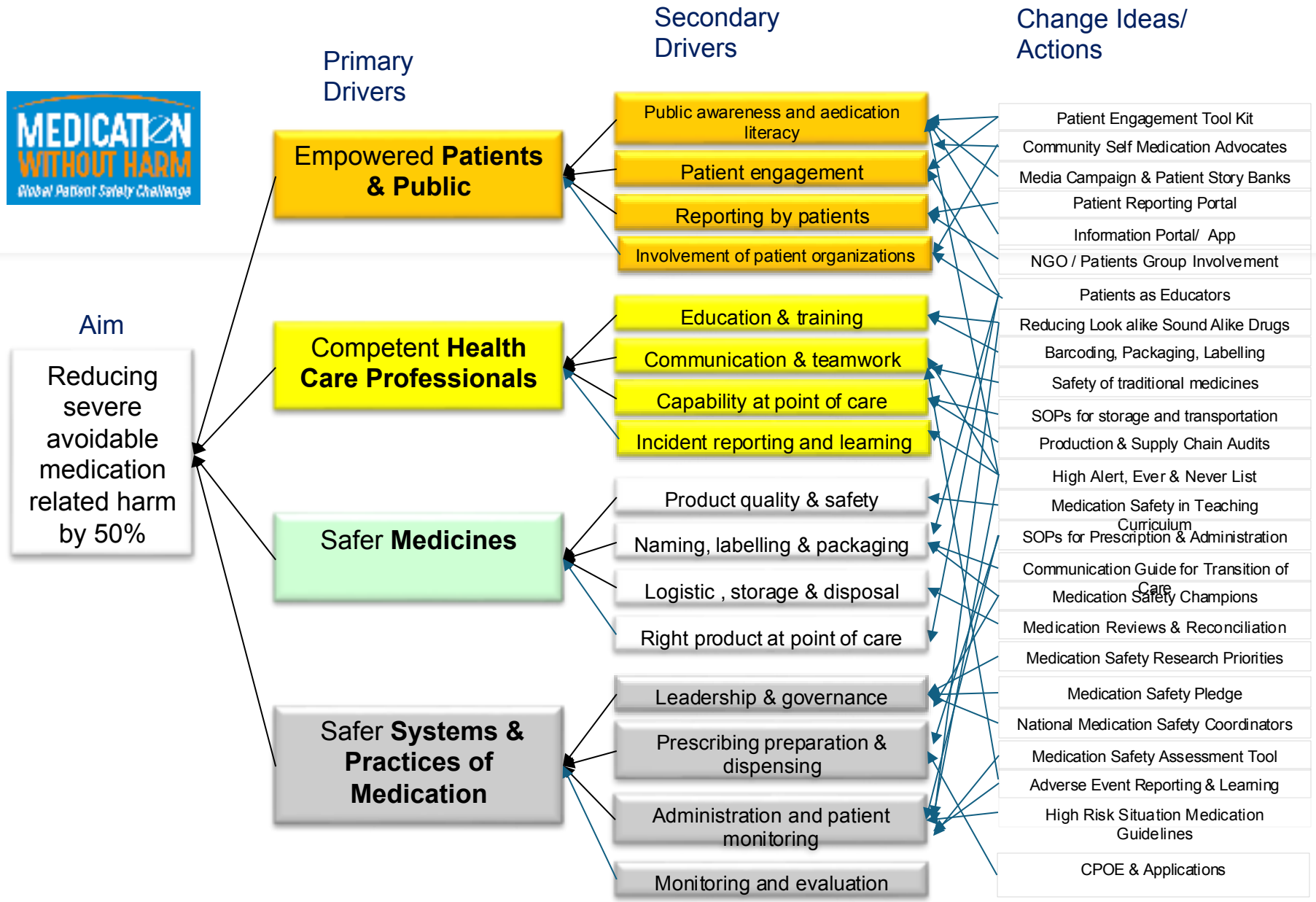
- A driver diagram is a visual tool used to display the relationship between a specific goal or aim and the factors that influence or ‘drive’ its achievement
- Helps teams and organizations to articulate theories of change and improvement
- Helps link broad strategies to specific actions, facilitating a structured approach to problem-solving, implementation, and continuous improvement
- This exercise will help in developing the implementation guide for patient safety

Process

- The Global Patient Safety Action Plan 2021-2030 is available online for reference and a background document will be provided for each strategic objective
- Session 5 participants have been assigned to join a working group
- There will be six groups in total, each with a moderator and WHO focal point
- Moderators will introduce themselves, initiate a round of introductions of group members and brief the group on the task and questions. They will moderate the discussion to ensure equal participation
- The group will select a rapporteur to record and synthesise discussions
- Both a printed and powerpoint version of the driver diagram is available for the recording of discussions and to use for presenting back to the wider group
- The rapporteur will present the summary of the discussion in the plenary session tomorrow

Components of a driver diagram:

- **Aim:** This is the overarching objective the we wants to achieve. It is typically framed in measurable terms, specifying *what* will improve, *by how much*, *for whom*, and *by when*.
- **Primary Drivers:** These are the key factors or high-level strategies that directly influence the achievement of the aim.
- **Secondary Drivers:** These are the specific actions or processes that support the primary drivers. Secondary drivers break down each primary driver into more detailed steps that contribute to its success.
- **Change Ideas:** These are the interventions or specific initiatives that are tested to influence the secondary drivers. Change ideas provide concrete actions the team can implement.


Primary Drivers
Secondary Drivers
Change Ideas/ Actions
Aim
Reducing severe avoidable medication related harm by 50%
Empowered Patients & Public
Competent Health Care Professionals
Safer Medicines
Safer Systems & Practices of Medication
Public awareness and aedication literacy
Patient engagement
Reporting by patients
Involvement of patient organizations
Education & training
Communication & teamwork
Capability at point of care
Incident reporting and learning
Product quality & safety
Naming, labelling & packaging
Logistic , storage & disposal
Right product at point of care
Leadership & governance
Prescribing preparation & dispensing
Administration and patient monitoring
Monitoring and evaluation
Patient Engagement Tool Kit
Community Self Medication Advocates
Media Campaign & Patient Story Banks
Patient Reporting Portal
Information Portal/ App
NGO / Patients Group Involvement
Patients as Educators
Reducing Look alike Sound Alike Drugs
Barcoding, Packaging, Labelling
Safety of traditional medicines
SOPs for storage and transportation
Production & Supply Chain Audits
High Alert, Ever & Never List
Medication Safety in Teaching Curriculum
SOPs for Prescription & Administration
Communication Guide for Transition of Care
Medication Safety Champions
Medication Reviews & Reconciliation
Medication Safety Research Priorities
Medication Safety Pledge
National Medication Safety Coordinators
Medication Safety Assessment Tool
Adverse Event Reporting & Learning
High Risk Situation Medication Guidelines
CPOE & Applications

Groups

Group 1 - Strategic Objective 1
Moderator: Melanie Leis
Note taker: Irina Papieva

Henrietta Hughes
Ingo Härtel
Ndella Konate
Reinavelle Jeunesse Mateo
Britta Gerloff

Aparna Singh Shah
Matteo Cesari
Upuli Wijemanne
Lydia Okutoyi
Patrizia Cuccaro

Group 2 - Strategic Objective 2
Moderator: Aidan Fowler
Note taker: Nikhil Gupta

Yin Shaqing
Tatiane Batista
Mustapha Elhousni
Tania Cardona
Giulia Dagliana

Michele Loiudice
Tuija Ikonen
Ferid Shannoun
Ratko Magjarević
Hardeep Singh

Group 3 - Strategic Objective 3
Moderator: Mondher Letaief
Note taker: Priyadarshani Galappatthy

Aline Cristina Pedroso
Mark Graber
Julia Tainijoki-Seyer
Federico Manetti
Carmen Crock
Kor Virya

Frédéric Cave
Carmel Moran
Tomris Özben
Caroline Samer
Gustavo Faissol Janot de Matos

Groups

Group 4 - Strategic Objective 4
Moderator: Helen Haskell
Note taker: Ayda Taha

Alex Adusei
Terence Vanginkel Wilde
Hussein Jafri
Antonia Gama
Maria Pilar Astier Peña
Ogusa Shibata
Annegret Hannawa
Sue Sheridan
Robert Velickovski
Mustapha Elhousni

Group 5 - Strategic Objective 5
Moderator: Paulo Sousa
Note taker: Alexandra Shaw

Javiera Esperanza Fuentes Contreras
Edwardo Haughton
Angeliki Karaiskou
Robert Velickovski
Ludjie Love Smeisschelle Merilan
Kazumi Tanaka
Wolf Hautz
Blerta Maliqi
Albert Wu

Group 6 - Strategic Objective 6
Moderator: Neelam Dhingra
Note taker: Diana Zandi

Laura Zwaan
Anthony Staines
Kelly M Smith
Malathi Arshanapalai
Ali Asery
Nurshaim Tilenbaeva
Jitendra Nath Srivastava
Abdulelah Alhawsawi
Masaru Kurihara
Shin Ushiro

Innovating for impact: the role of implementation science in patient safety

Prof Albert Wilson WU
Professor, Health Policy and Management
Johns Hopkins Bloomberg School of Public Health Baltimore
USA

World Health Organization

World Patient Safety Day 17 September 2024

Innovating for Impact: the Role of Implementation Science in Patient Safety

WPSD 2024 Global Consultation
Geneva 11 September 2024

Albert W. Wu, MD, MPH
Johns Hopkins Bloomberg School of Public Health
Armstrong Institute for Patient Safety and Quality

Between the idea
And the reality
Between the motion
And the act
Falls the Shadow

Excerpt from the poem,
The Hollow Men, by
T.S. Eliot (1888-1965)

World Patient Safety Day 17 September 2024

Objectives

- Explain the importance of “implementation science to effective DXE interventions
- Explain why implementation must incorporate local knowledge
- Describe”4 Es” for translating research into practice

World Patient Safety Day 17 September 2024

Implementation Research

DEFINITION

- The scientific study of methods to promote the systematic uptake of research findings and other evidence-based practices into routine practice, and, hence, to improve the quality and effectiveness of health services and care
- This relatively new field includes the study of influences on healthcare professional and organizational behavior.

Wu 2024

World Patient Safety Day 17 September 2024

Implementation as Bridge Building

- …between research & practice
- (Also, between providers & consumers)
- To facilitate uptake of **effective** procedures in **specific** healthcare settings
- Goal is to *get things to work*

Wu 2024

World Patient Safety Day 17 September 2024

Generalizable Knowledge, Local Knowledge

Each health care setting is a unique implementation task

- Intervention based on **generalizable knowledge**
- Implementation must incorporate **local knowledge**
  - Organizational culture
  - Financial constraints
  - Resource availability (such as IT support)
  - Provider beliefs and attitudes
  - Person / family beliefs / attitudes
- Integration of local knowledge requires problem-solving that adapts and improvises to accommodate prevailing local conditions

Wu 2024

World Patient Safety Day 17 September 2024

Example

Delayed communication, follow-up and resolution of abnormal **mammograms** limits early detection efforts and causes psychological distress and anxiety

INTERVENTION

Radiology department contacts women directly rather than waiting for provider to communicate results

EFFICACY

Increased rate of follow up testing and resolution

Wu 2024

Drop: From Potential Efficacy of Intervention to Actual Results

Eisenberg J. JAMA 2000

World Patient Safety Day 17 September 2024

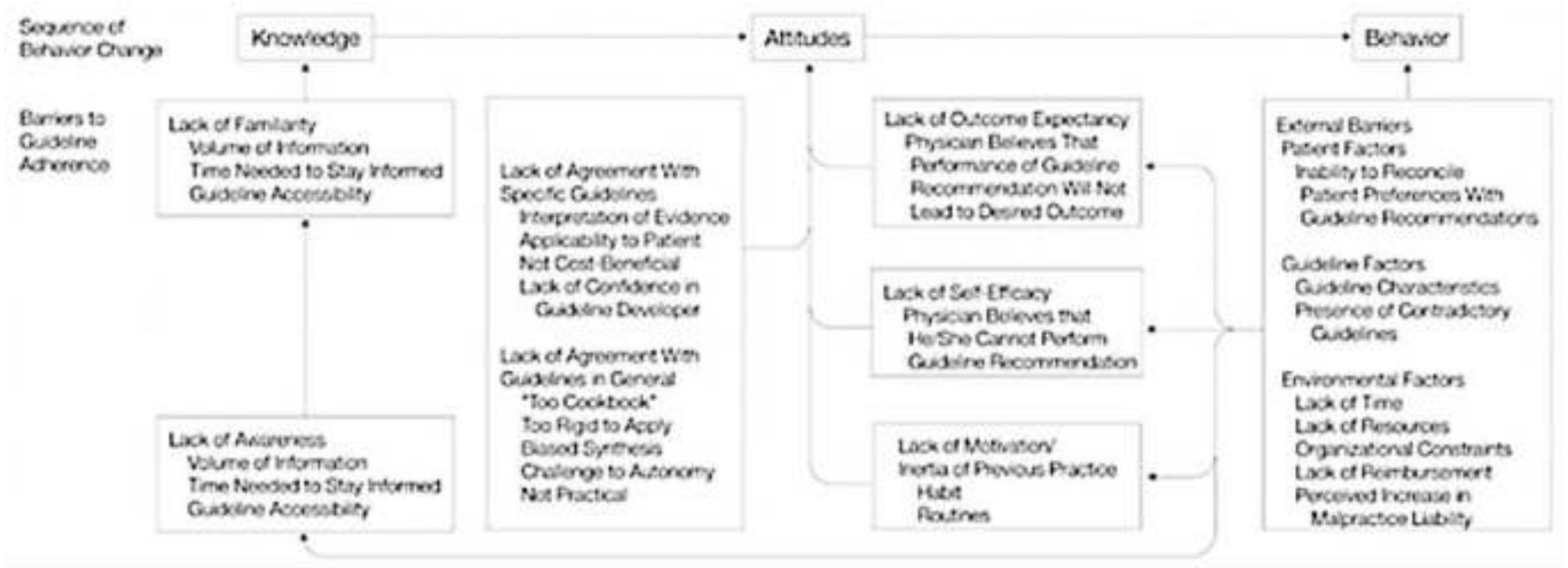
Identify Local Barriers to Implementation

- The intervention will be part of a work process
- What is the context surrounding this work?
- Walk through steps with provide to observe what is required to implement intervention
  - Where are the failure points?
  - What could be done to improve compliance?

Wu 2024

From: **Cabana M et al. Why Don't Physicians Follow Clinical Practice Guidelines?: A Framework for Improvement**

JAMA. 1999;282(15):1458-1465. doi:10.1001/jama.282.15.1458



World Patient Safety Day 17 September 2024

Change is Hard

If you want to truly understand something, try to change it.

-Kurt Lewin (founder of modern social psychology and change theory)

Understanding Context

- To help understand the context in which the intervention will be implemented, ask all stakeholders why it is difficult or easy for them to comply with recommended practices
- Listen carefully and learn what staff may gain or lose from implementing the intervention

Measure Performance

Need performance measures

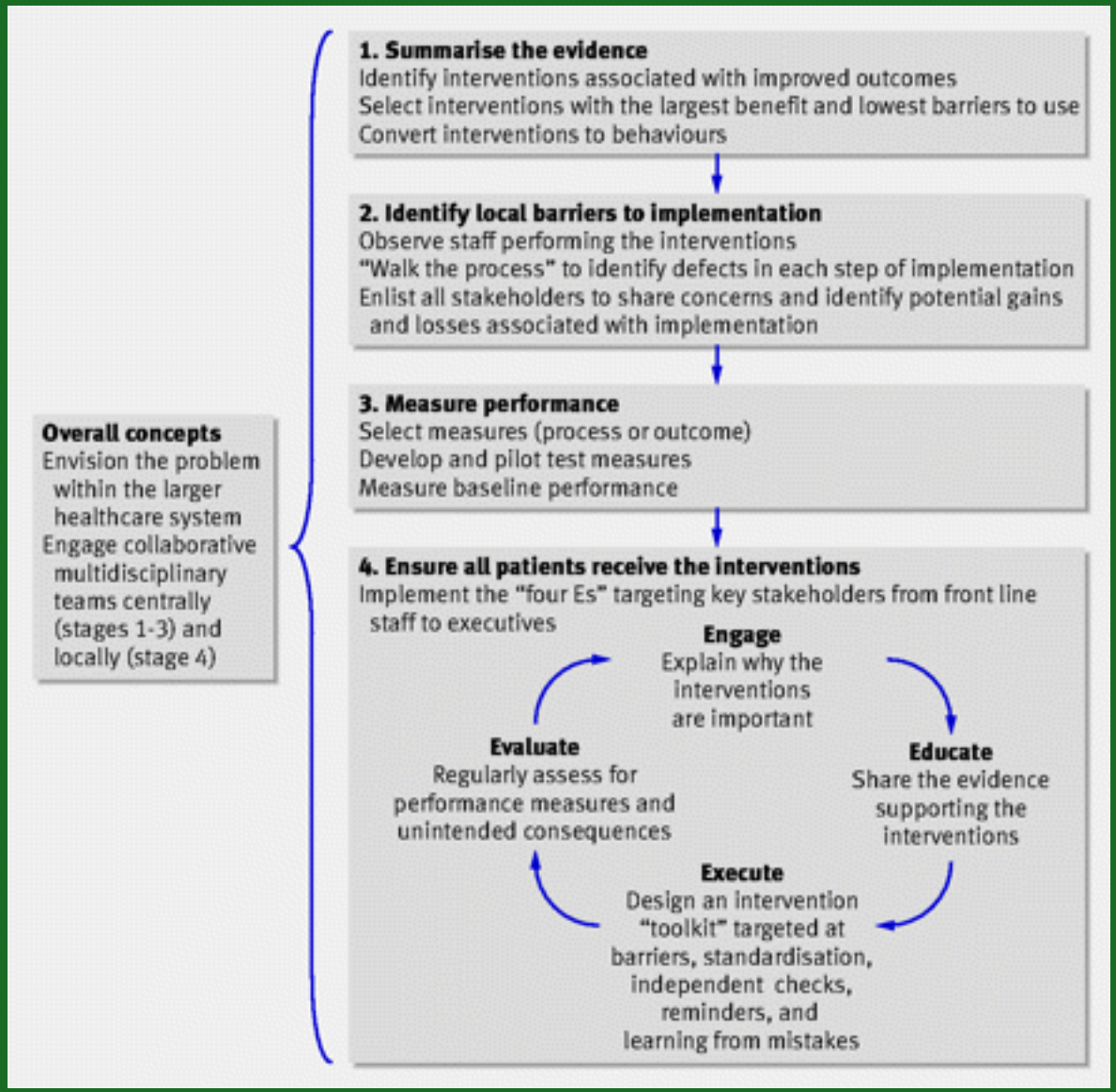
- How often do patients actually receive the recommended intervention (process measures)
- Do patient outcomes improve (outcome measures)
- Outcome measures are preferred if valid and feasible

Measures

- Teams use quantitative measures to determine if a specific change actually leads to an improvement.
- Many sequential, observable tests
- Gather "just enough" data to learn and complete another cycle
- "Small tests of significant changes" accelerates the rate of improvement

Strategy for Translating Evidence to Practice

- Simplify the steps
- Identify local barriers
- Understand context
- Measure performance
- Ensure reliability



Pronovost, BMJ 2008

Ensure All Patients Receive the Intervention

The 4 “Es”

- Most complex stage: Ensure that all patients get the intervention
- Interventions must fit local system, including culture and resources
- 4 “Es”
  - Engage
  - Educate
  - Execute
  - Evaluate

Wu 2024

Engage

- Share real life stories of patients
- Estimate the harm attributable to omitting the intervention in the local organization based on their own data
- Inform each unit of its annual number of delayed notifications

Educate

- All relevant staff
- Published evidence supporting the proposed intervention
- Concise summary
- Checklist of the evidence?

Execute

- Design an implementation manual or toolkit based on identified barriers to implementation
- Based on 3 principles for redesigning care
  - standardize care processes
  - create independent checks (such as checklists)
  - learn from mistakes

Evaluate

Process Measures

- Numbers of Processes delivered per mammogram
- Time to treatment

Outcome Measures

- PREMS and PROMS

“Let our advance worrying become advance thinking and planning.”

Winston Churchill

SUMMARY

- Implementation requires generalized and local knowledge (technical + adaptive work)
- A strategy to translate evidence into practice includes steps to
  - Simplify the process
  - Identify local barriers
  - Understand context
  - Measure performance
- Ensure reliable uptake by following ”4 Es”
  - Engagement, Education, Execution, Evaluation
- Can be applied to LMIC
- Add consideration of barriers and evaluation to DXE Implementation Model

World Patient Safety Day 17 September 2024

Questions?

World Patient Safety Day 17 September 2024

Editorial

Getting the diagnosis right: World Patient Safety Day 2024

Journal of Patient Safety and Risk Management
1–4

DOI: 10.1177/25160435241277452
journals.sagepub.com/home/cri
Sage

> …the most crucial step toward healing is having the right diagnosis. If the disease is precisely identified, a good resolution is far more likely. Conversely, a bad diagnosis usually means a bad outcome, no matter how skilled the physician. (Andrew Weil)

Scientific and medical advances in the last two centuries have revolutionized healthcare, transforming it into an endeavor that can prolong and improve life. These advances include the ability to diagnose a patient's health problem in a holistic way, which then indicates the steps needed to prevent or mitigate adverse consequences. Diagnosis plays a central, multifaceted role in healthcare and health, influencing lifestyle, health promotion, disease prevention, treatment, and recovery. Correct and timely diagnosis is dependent upon strong health systems, effective and efficient design planning, and the capacity to deliver safe and high-quality care.

Diagnosis is not the end, but the beginning of practice. Early diagnosis can be crucial to detecting a disease where curative treatment options are available. Accurate diagnosis can improve patient outcomes, enhance patient trust, lead to efficient resource utilization, and reduce the overall burden on healthcare systems. Today, safer diagnosis is important for many reasons: to direct efforts for prevention and treatment, for planning, informing, and reassuring, and to inform policy, resource allocation, and research priorities.

biases, with the potential for targeted and broad interventions.[2–4] It can involve failures in gathering and synthesizing information due to lack of competency, communication failures, complex workflows, repetitive tasks, distractions and interruptions, inadequate follow-ups, or premature closure. Other broader system-related factors include inadequate staffing levels, high patient flows, resource availability, and technological issues. Cognitive biases including predispositions in one's responses based on experience or current condition are another important factor leading to diagnostic errors.[5]

For example, a systematic review found that 64% of closed malpractice claims are due to diagnostic errors, with 79% of those cases including a "failure of judgment."[6] Patient-related factors such as providing incomplete information, or cognitive or physical impairment might have a bearing on reaching the correct diagnosis.

Sadly, most adults are likely to face at least one diagnostic error in their lifetime, a statistic that shows the substantial work required to improve the safety of diagnostic processes. It has been estimated that diagnostic errors contribute to 10% of patient deaths, harming or killing 795,000 people in the US annually.[7] Although data are scarce, rates may be higher in low- and middle-income countries.[8] Globally, diagnostic errors account for nearly 16% of preventable harm across health systems.[9] There is substantial evidence that marginalized groups face a disproportionate burden of harm due to diagnostic errors.[10–16]


World
Patient Safety
Day 17 September 2024
awu@jhu.edu

Closing remarks of Day 2

Sir Liam DONALDSON
WHO Envoy for
Patient Safety
WHO HQ
Switzerland

World Health Organization

World Patient Safety Day 17 September 2024