# 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 6 - Future of global patient safety: mid and long-term perspective

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# Recap of Day 2

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# Group work on diagnostic safety implementation model

1. Proposed attributes: broad agreement on the 5 attributes
   - Additional: e.g., Collaborative, Ethical, Evidence-based, People centered vs patient centered
2. Implementation model
   - General concept: agreement on importance of having an implementation model to improve diagnostic safety
   - Structure to be improved: e.g., patients in the center, adding just culture and human factors as cross-cutting elements
3. Proposed interventions
   - Focus on patient perspective, co-creation with patients (streamlining the concept of patient agency)
   - Language: more action verbs, e.g., practice vs promote
   - Additional: leadership, financing, resources
   - Embedding the concept of 'evaluate/measure/improve'
   - Choosing wisely: prioritization is important
4. Best practices or innovative approaches
   - Need for research and measurement
   - Incorporate existing tools and resources (e.g., PREMs and PROMS)

Four groups

1. Health workers
2. Patients and representatives
3. Systems and processes
4. Diagnostics and technology

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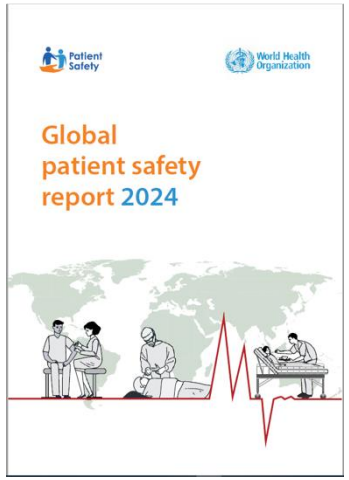


# Implementing the GPSAP 2021-2030

Modes of Implementation

- Advocacy
- Technical guidance
- Country support
- Coordination
- Monitoring

**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**

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# Patient Safety: the communication science and implementation science perspectives

- Communication is our most innate safety process and the most powerful resource we have.
- Most harm occurs due to communication breakdown
- Patient is harmed or healed based on how we communicate
- Unsafe communication is expensive
- Communication involves more than techniques – needs competency development

- Implementation science as a bridge building between research & practice
- To facilitate uptake of effective procedures in specific healthcare settings
- Goal is to *get things to work*
- Interventions are based on generalizable knowledge while Implementation must incorporate local knowledge
  - the 4 Es – Engage, Educate, Execute and Evaluate

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# Experiences at country and regional level

- Policy development: Malta
- Legislation on Patient Safety Rights Charter: Sri Lanka
- Point of care improvement programs: Cambodia
- Incident reporting and learning systems: Morocco
- Partnerships (Global Ministerial Summits): Chile (last host) and the Philippines (next host)

- Diverse systems within the regions: adaptation of the strategies to the local contexts is essential
- Challenges
  - Conflict situations in some regions
  - Needs and priorities for patient safety vary significantly both between and within countries (e.g., data-related, resources, safety culture, incident reporting and learning systems, legislation)
- Opportunities
  - Political commitment - maintaining momentum
  - Support from assessment to implementation and monitoring (whole continuum)
  - Twinning partnerships and collaborations
  - Innovative solutions (e.g., the club for QoC and PS innovators)
- Still a long way to go to implement the GPSAP, especially across some SOs and strategies: e.g., patient and family engagement, competency development
- Patient safety to be a prerequisite and not a priority (example of aviation)

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# GPSAP : recalibrating the compass

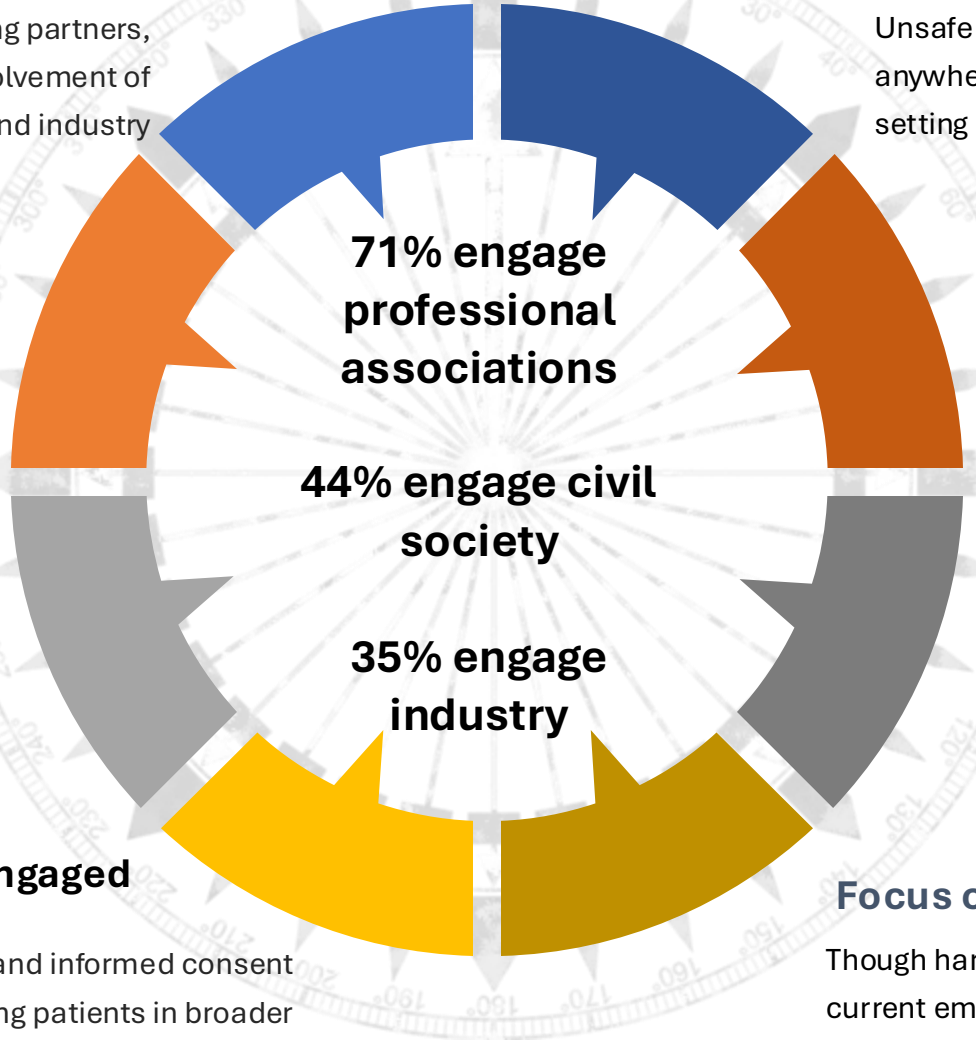
**Move through**
Designing
Introduction
Promotion
Expansion
Consolidation
Sustenance
Evaluation

### 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

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# Group Presentations

By Rapporteurs from the six groups

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# Group 1 Presentation

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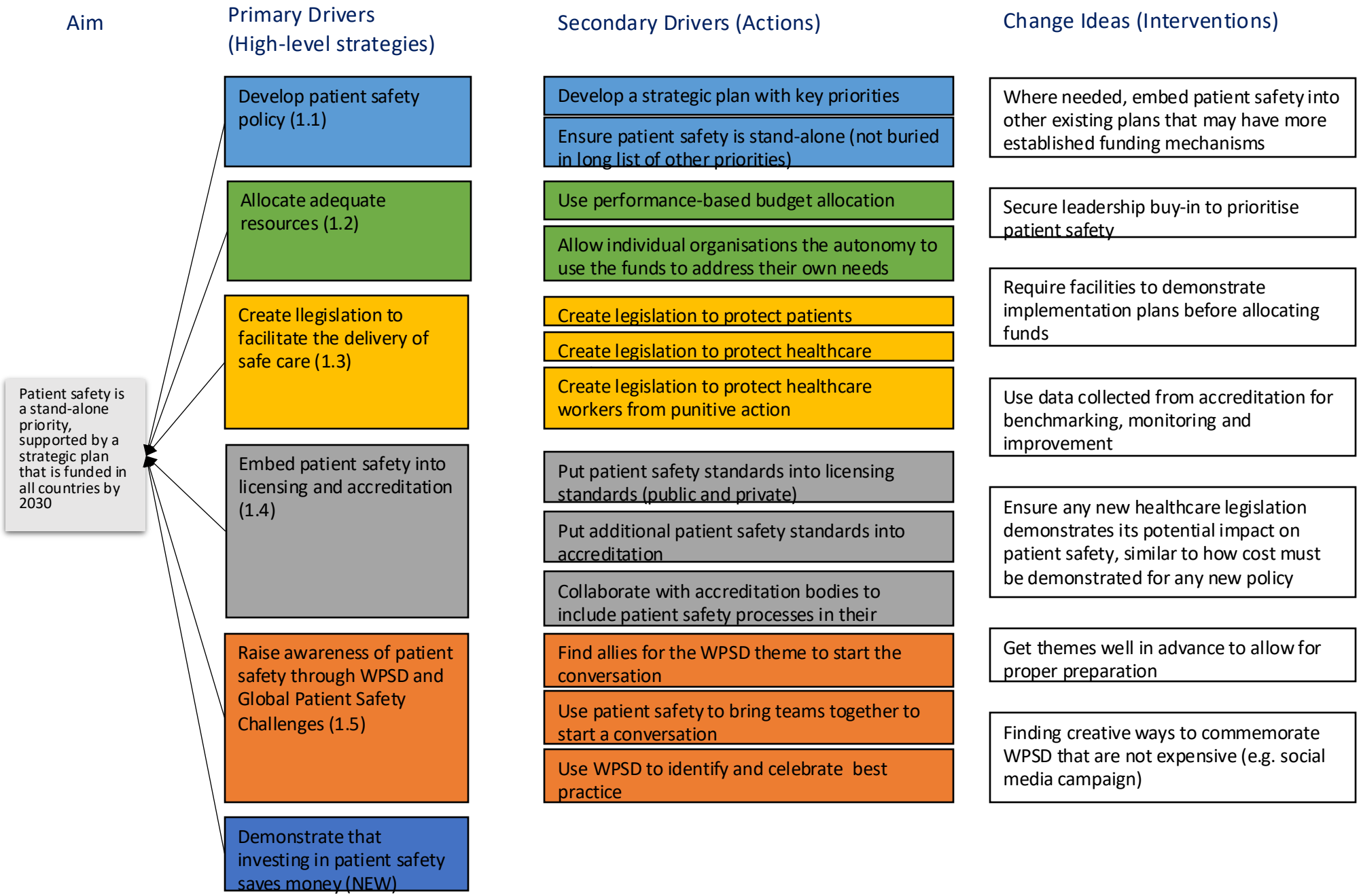
Strategic Objective 1 - **Policies to eliminate avoidable harm in health care**



# Group 2 Presentation

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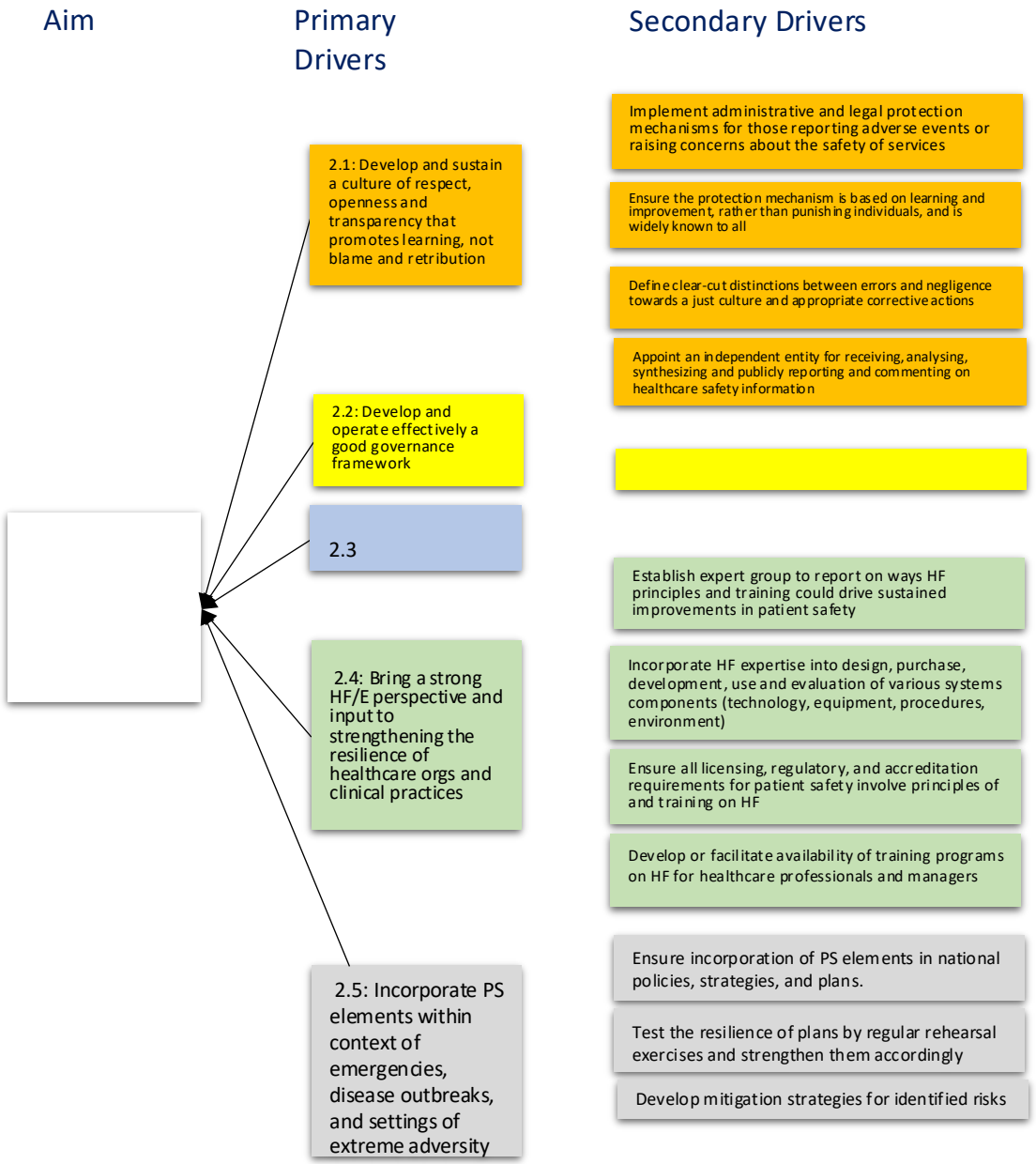
Strategic Objective 2 – High-reliability systems




## Change Ideas

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|---|
| Patient Safety Protection Act (USA) to protect internal investigations |
| National mandate to put in place a process of establishing minimum professional standards, and to appoint a reviewer to assess individuals based on these standards. |
| Viable "independent entity" include patient organizations, public health institutions, academic bodies, provided they possess the relevant expertise. |
| |
| Establish a "global cooperative" that holds national leaders of healthcare (e.g. ministers) accountable for patient safety, and have them appoint senior executives to support patient safety efforts and monitoring. |
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|---|
| Establish a national standard that lists requirements in utilizing and integrating HF principles in healthcare operations; consider a certification program |
| Redefine payment model that emphasizes and rewards effort (e.g. physician protected time) put in towards patient safety endeavors: Insurance, malpractice claims, value-based capitation |
| Mandate capabilities for HF services in healthcare operations: embed HF specialists, engage professional HF services, partner with academic scholars, formally educate clinical / non-clinical staff, strategically train for specific competencies and mindset |
| Work with professional HF societies to provide support and resources for healthcare institutions embarking on HF advocacy and capacity building. |
| Establish HF expertise within patient safety / licensing / regulatory requirements at the national level, to shape patient safety initiatives and regulations with HF considerations |
| |
| |
| Identify specific patient safety / operational risk concerns throughout an emergency response plan, and test-retest for performance resilience under stressful emergency conditions; Ensure processes are robust and adequately designed + supported to withstand extreme settings. |
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# Other reflections and suggestions for implementation

- Given the varying readiness and resources among different countries and healthcare institutions, we should allow for “different roads, same destination”
- WHO can provide a collaborative platform to support, compare, and drive progress in safety and high-reliability standards across all members

# Group 3 Presentation

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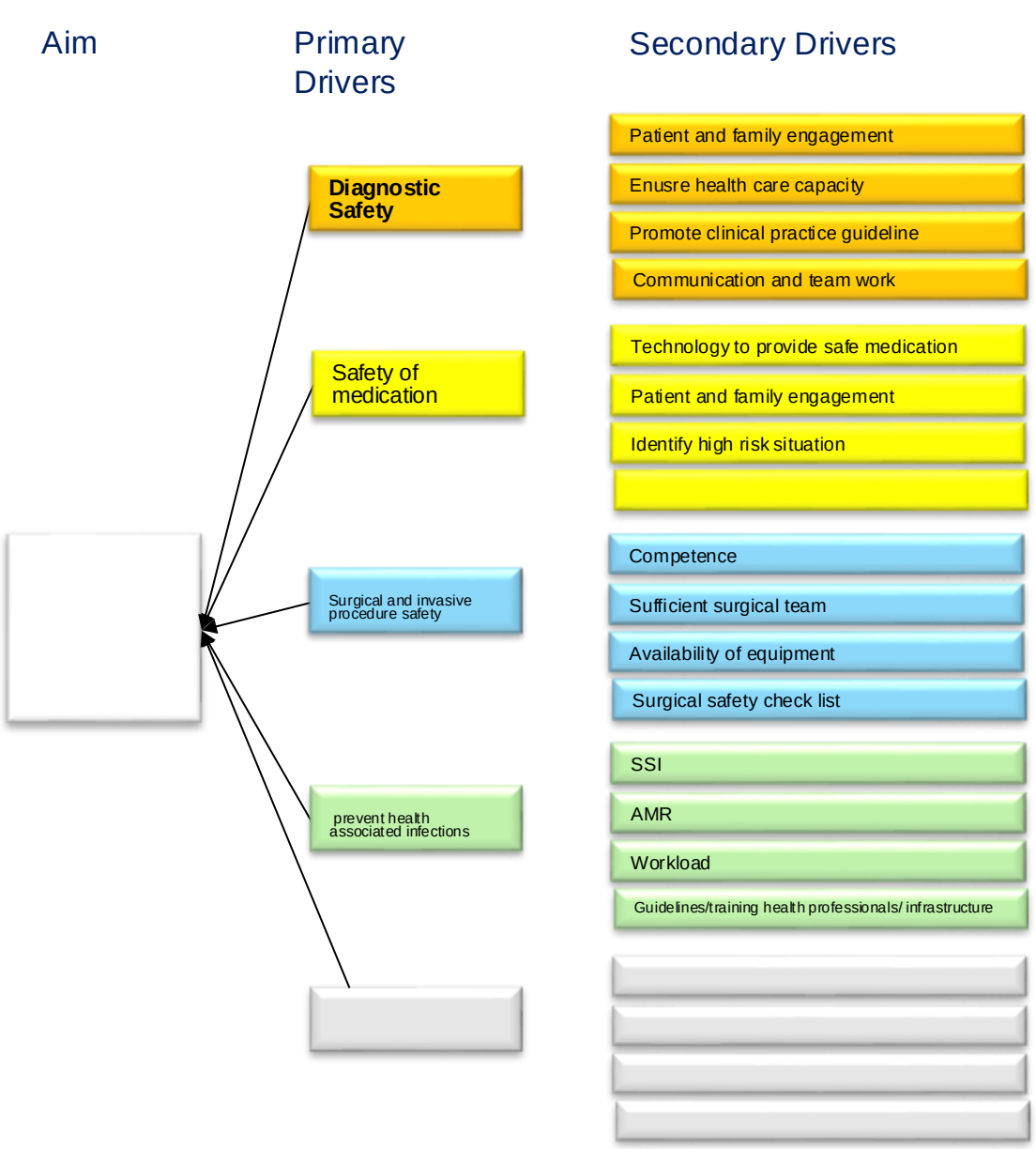
Strategic Objective 3– To improve the safety of every clinical procedure to overall score of 80% by 2030




## Change Ideas

- Educate family and patient
- Timely access with expertise
- Supervision, monitoring and feedback
- Decision support and technology support
- Checklist
- Implement five steps of safe medication
- Encourage report system for failures and errors and potential errors
- Identify patients with polypharmacy or on high-risk medication
- Check equipment and sterilisation
- Protocols and guidelines
- Assess appropriateness of surgical procedure
- Promoting ambulatory post-surgical recovery
- Measuring patient experiences – PREMS and PROMS
- Body temperature, glucose control and prophylactic antibiotic
- Antibiotic stewardship
- Encourage patient to speak up
- Twinning hospitals and benchmarking
- Essential equipment

# Group 4 Presentation

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**Aim:**

Strategic Objective 4: Patient and Family Engagement – Engage and empower patients and families to help and support the journey to safer health care

**Primary drivers (pretty much the strategies already outlined in the GPSAP):**

1. **Strategy 4.1:** Engage patients, families and civil society organizations (CSO) in the co-development of policies
2. **Strategy 4.2:** Learn from the lived experience of patients and families to foster more effective solutions
3. **Strategy 4.3:** Build the capacity of patient advocates and champions in PS
4. **Strategy 4.4:** Openness and transparency throughout healthcare
5. **Strategy 4.5:** Provide information and education to patients and families for their involvement in self-care and empower them for shared decision-making

**Secondary drivers:**

We slightly rearranged the “Actions for governments” to fit into the implementation model, but, overall, the group felt the primary and secondary drivers are comprehensive enough.

**Change ideas at government level:**

- Budget and infrastructure to support civil society organizations
  - Support and build the capacity of patient groups and CSO to secure grants and contracts to ensure sustainability, e.g. for safety improvement networks
- Monitoring and evaluation system of activities being implemented to support patient safety at the national level
  - Accountability mechanism
- Development of internal procedures to recruit patients and CSO (to match existing initiatives with the need to promote multi-stakeholder collaborations)
- Once recruited, these representatives could act as consultants in National Advisory Councils and collaborate, for instance, with definitions according to national specificities
- Capacity building: develop quality, safety and prevention improvement training, including to improve leadership and communication skills
- Promote partnerships between health promotion departments and patient safety programs
- Education of patients at the point of care: co-develop educational awareness materials with patients to be widely disseminated to the general public (instead of to the patient safety community only)

# Group 5 Presentation

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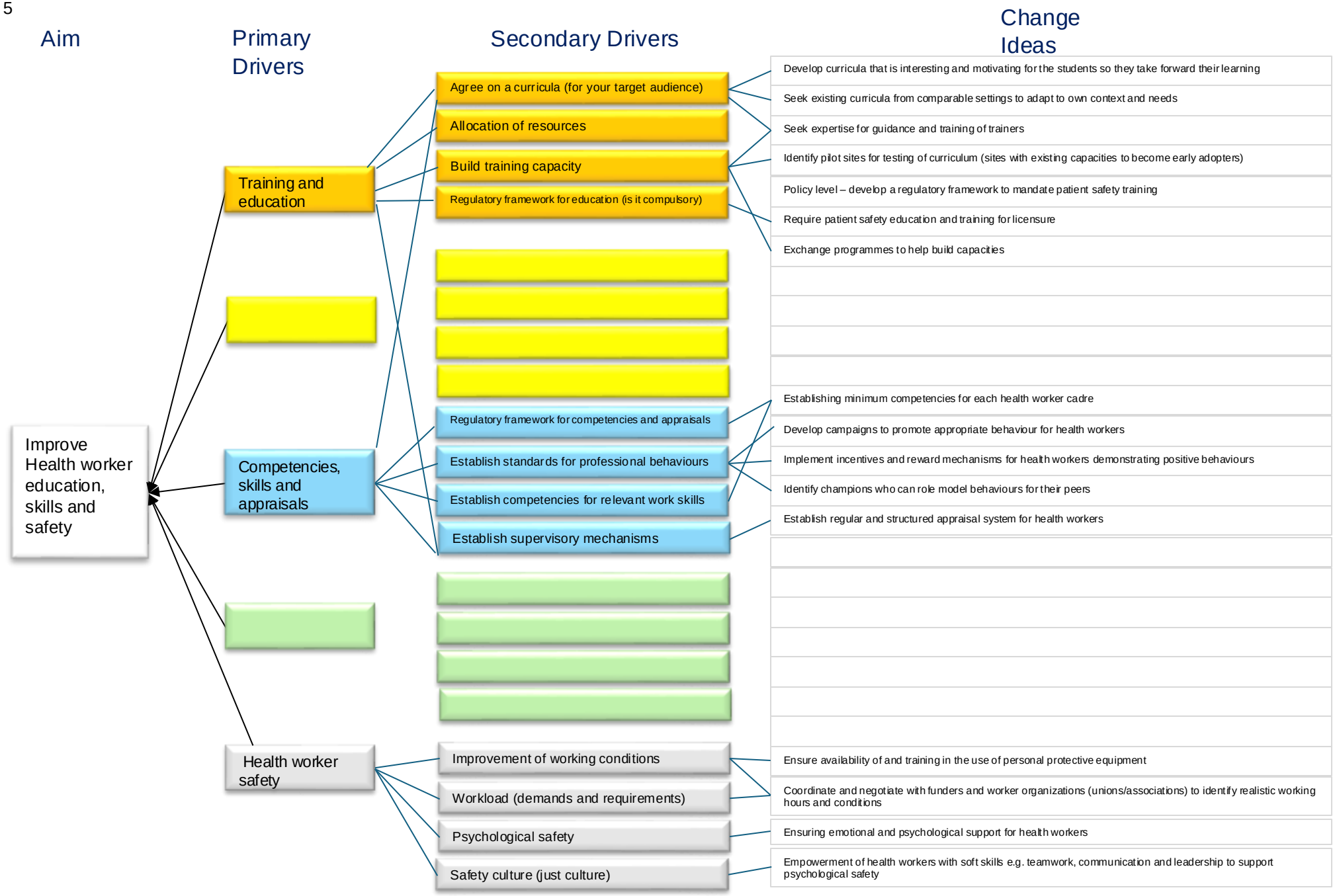
Strategic Objective - 5



# Group 6 Presentation

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# THOUGHT LEADERS

STRATEGIC OBJECTIVE - 6

GROUP 6

## INFORMATION, RESEARCH & RISK MANAGEMENT

Strategic Objective – 6: **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**

# ATTRIBUTES

- **WHAT** – ZERO AVOIDABLE HARM
- **HOW** – APPROPRIATE COLLECTION, UTILIZATION, EXPERIENCE, INSIGHTS, EVIDENCE BASED PRACTICES TO IMPROVE SAFETY
- **FOR WHOM** – MACRO, MESO, MICRO LEVELS
- **BY WHEN** - 2030

Strategic Objective – 6: **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**

## Aim

To reduce healthcare risk and achieve zero avoidable harm by the collection and appropriate utilization of data, experiences, and insights, development of (evidence generation) and implementation of (evidence use) leading practices to improve patient safety at the macro, meso, and micro levels of the global health system.

## Primary Drivers

- **6.1 Implement patient safety reporting systems to enable a learning system**
- 6.2 **Utilize all sources of data, insights, and experiences**
- **6.3Measure and Monitor the burdens and causes of harm in healthcare**
- **6.4 Generate NEW evidence and methods; and SYNTHESIZE and TRANSLATE (Implement) existing and new evidence into practice**
- **6.5 Adopt and integrate digital technologies**

## Secondary Drivers

- Establish standards and guidelines for reporting learning systems
- Identify public and private organizations to advance reporting learning systems that are contextually relevant (aligned with health burden/priorities)
- Develop a system for reporting for monitoring, feedback, and learning
- Develop capacity for reporting, monitoring, feedback, and learning
- Develop a learning culture and culture of curiosity
- Develop a data landscape for risk and harm at the macro, meso, and micro system levels
- Develop local, regional, national capacity for utilizing all sources of data, insights, and experiences to advance safety
- Integrate of sources of data
- Implement and operationalize independent review mechanism with in-depth analysis
- Develop capacity for measuring and monitoring burdens of harm
- Create a non-punitive culture
- Create Culturse of Safety
- Prioritize and identify the need for operational research in patient safety at the macro, meso, micro level.
- Create a culture of learning, improvement, and curiosity
- Build capacity for operational and implementation research
- Integrate artificial intelligence and machine learning within medical records (electronic) to predict risks
- Develop safety and ethic protocols for supervision and oversight of digital technologies
- Public/Private partnerships to develop clear standards for safety protocols for digital technologies

## Change Ideas

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| Develop voluntary/mandatory reporting standards |
| Create, adopt, or adapt existing reporting tools |
| Include equity sensitive factors in monitoring systems |
| Create, adopt, or adapt training tools to for reporting, monitoring, feedback, and learning |
| Create actionable data to inform practice changes |
| |
| Create actionable data to inform practice changes |
| List all sources of data |
| Develop and advance training programs to create local skills for data use |
| PROMS, PREMS, Community engagement |
| Develop access to all sources of data (including associations, insurers, etc |
| Audits, reviews and risk assessment |
| Develop standard processes for event review (RCA; investigation; National Safety Boards) |
| Create standards for training and competency maintenance for individuals performing reviews |
| Develop standards for measuring and monitoring to establish feedback and reporting back to macro,meso, micro levels |
| Provision of resources |
| Develop a scientific agenda to advance patient safety at the macro level |
| Advocate for funding/mandate for a dedicated patient safety research institute |
| Creating opportunities not only to generate new innovations but also to share them locally, regionally, and nationally |
| Leverage healthcare workforce training (e.g., MD, RN, other healthcare professionals) to research patient safety problems locally |
| Provide research agenda that includes training of researchers; fellows; etc. |
| Data protection, privacy, interoperability of EMR |
| Establish a system to identify technologies and a process for adoption |
| Identify partners |
| Identify tools for improving patient safety |
| Develop and implement tools for evaluating patient safety risks of digital technologies |
| |
| |

# Other reflections and suggestions for implementation

- Need to consider equity within each strategy
- Information may not only be curated in electronic sources
- Strategies are not setting specific (may need unit specific interventions, geography, regulatory compliances)

# Discussion and Q and A

## Moderator

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# GPSAP 2021-2030 implementation guide

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# Patient Safety Implementation Guide

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# Rationale and objectives

- To provide step-by-step guidance for implementing patient safety programs at system and health care facility level
- To offer normative guidance and share best practices from health care systems
- To explain key patient safety concepts and strategies
- To offer policy and practice options for different resource settings
- To provide strategies for integrating patient safety into health system strengthening
- To create a directory of patient safety resources and references

# Concept

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- **S** Situational Analysis
- **A** Advocacy and Stakeholder Engagement
- **F** Frame Policies, Strategies, and Frameworks
- **E** Establish Operational Plans and Institutional Arrangements
- **T** Target Priority Actions and High-Impact Interventions
- **Y** Yield Standards and Guidelines
- **F** Facilitate Continuous Monitoring
- **I** Innovate and improvise
- **R** Report Progress and Success Stories
- **S** Scale up implmentation
- **T** Tune and Update the Plan

# S – Situational Analysis

- Assess the current state of patient safety
- Identify gaps, challenges, and areas for improvement
- Analyze patient safety data (incident reports, outcomes, burden of harm)
- Consider local healthcare infrastructure and cultural context
- Define priorities based on the analysis

# A – Advocacy and Stakeholder Engagement

- Drive advocacy for patient safety at all levels
- Engage key stakeholders (healthcare providers, policymakers, patient organizations)
- Build political and organizational commitment
- Foster multi-sectoral partnerships
- Ensure collective action for patient safety

# F – Frame Policies, Strategies and accountability Frameworks

- Develop legislative and statutory environment
- Patient safety policy and strategies
- Develop/align a comprehensive national and subnational institutional structures
- Align policies with global mandates and local priorities
- Ensure accountability and support for implementation
- Provide a foundation for safety improvement efforts

# E – Establish Operational Plans and Institutional Arrangements

- Develop patient safety action plan with roles and timelines
- Allocate necessary resources for patient safety
- Set up patient safety committees or task forces
- Ensure oversight and governance of safety initiatives
- Enable long-term sustainability of safety practices

# T – Target Priority Actions and High-Impact Interventions

- Focus on high-priority safety actions
- Prioritize interventions with the highest potential impact
- Align interventions with global safety standards
- Allocate resources efficiently for maximum results
- Tailor interventions to local healthcare needs

# Y – Yield Standards and Guidelines

- Develop clear, evidence-based safety standards
- Create protocols for key clinical safety domains
- Integrate guidelines into routine healthcare practices
- Monitor compliance with safety standards
- Reduce variability and prevent harm

# F – Facilitate Continuous Monitoring

- Establish systems for continuous safety monitoring
- Track safety incidents and compliance with protocols
- Use data to assess performance and adjust interventions
- Maintain accountability in safety practices
- Ensure that safety measures deliver desired results

# I – Innovate and Improvise

- Encourage the adoption of new technologies
- Promote innovative practices to address safety challenges
- Stay flexible and open to improvisation
- Adapt strategies to changing healthcare landscapes
- Foster a culture of innovation in safety

# R - Report Progress and Success Stories

- Share progress and outcomes of safety interventions
- Highlight key achievements and improvements
- Showcase success stories to inspire further commitment
- Build trust and credibility through transparent reporting
- Encourage the broader adoption of safety measures

# S – Scale Up Implementation

- Expand successful safety interventions across the healthcare system
- Adapt interventions for different healthcare settings
- Ensure widespread application of safety practices
- Maintain fidelity to the original safety goals
- Achieve long-term, system-wide improvements

# Tune and Update the Plan

- Regularly review and update the patient safety action plan
- Incorporate new evidence, trends, and feedback
- Ensure alignment with emerging healthcare challenges
- Keep the plan dynamic and responsive
- Sustain improvements over time through continuous updates

# Next steps

- Global consultation on implementation of GPSAP
- Expert Group Formation
- Scoping and Outline
- Content Development - Health systems and Health care facilities (Two modules)
- Case Study and Best Practices Compilation
- Second Consultation for Review and Feedback on First Draft
- Revision of Document Based on Feedback
- Finalization, production and dissemination of implementation guide

# Thank You

# Open dialogue
# Convergence for safety: integrated approach to implementation

## Moderator

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# Patient safety: continuity and change

Sir Liam DONALDSON
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# How stakeholders can accelerate the implementation of the GPSAP

**Moderator**

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- Patient and Civil Society organizations:
  - IAPO, WPA
- Academic institutions:
  - ICL
- WHO Collaborating centres
  - NOVA University Portugal, NHSRC India
- Professional organizations
  - WMA, IUPHAR
- Non-profit organizations:
  - JCI

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Joint Commission International

# International Patient Safety *Pathways* Initiative

## Vision

- A strategic Initiative to support development of patient safety and quality improvement programs at **national** and **subnational** levels, in countries across the world
- Involves working with ministries of health, national, and international partners, and healthcare organizations, **in various stages of development**, to make progressive advancements in providing safer patient care
- Aligned with The Joint Commission's transformation journey and its vision "**All people always experience the safest, highest quality, and best-value healthcare at all settings worldwide**"

Joint Commission International

# International Patient Safety *Pathways* Initiative

## Implementation

- High-level advocacy, policy guidance, and needs assessment using structured tools
- Action planning, implementation support, capability building, and demonstrable improvements
- Country commitment
  - Leadership engagement, ownership and capability
  - Training of trainers, HR education and training
  - Minimum common elements
- JCI recognition to those achieving patient safety and quality goals and milestones

# Key Messages

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# Closing remarks by Assistant Director General

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