WHO PATIENT SAFETY PROGRAMME

3rd Annual Conference on Safety, Standards and Customer Services

Lagos 13th and 14th October 2011

Carmen Audera-Lopez
WHO Patient Safety
WHAT IS PATIENT SAFETY

Patient safety is the absence of avoidable harm to patients during the process of health care.

The International Classification for Patient Safety describes patient safety as the reduction of risk of unnecessary harm associated with health care to an acceptable minimum.

An acceptable minimum refers to the collective notions of given current knowledge, resources available and the context in which care was delivered.
A 23 year old women in her first pregnancy delivered a baby boy by normal vaginal delivery in the hospital, but patient developed postpartum haemorrhage. She was not under immediate close observation following the delivery. Several hours later she was taken to operating theatre and was given blood and fluid resuscitation. On examination the uterus was very lax. Ergometrine were administered, but still uterus was lax. Finally a laparotomy was performed and a hysterectomy was done. The patient died on the operating table.

This should not have happened!!!
WHAT IS PATIENT SAFETY

Patient safety:

- A critical dimension of quality:
- Should be considered within the context of health care delivery and health systems.
- An issue for all countries: Nature of problems is certainly different -

There are two types of problems:

- Those related to commission
- Those related to omission- (need to differentiate from lack of resources)
Why is patient safety a global public health problem

Every year, tens of millions of patients worldwide suffer disabling injuries or death due to unsafe medical care.
Some data

Estimates show that in developed countries as many as one in 10 patients is harmed while receiving hospital care.

The harm can be caused by a range of errors or adverse events.

An adverse event is an incident which resulted in harm to a patient (including omission)
Adverse events in health care: Developed and developing countries

Developed countries
Health Care Associated Infections:
• 5 million HCAI estimated to occur in hospitals in Europe/year
• 1.7 million HCAI in USA - about 100,000 deaths

Developing countries
Health Care Associated Infections:
• Neonatal HCAI up to 20 times higher in developing world
• Risk of Surgical Site Infection is higher than developed world: 40% in paediatrics (Nigeria); 23% general surgery (Tanzania); 19% in maternity (Kenya)
Adverse events in health care: Developed and developing countries

**Developed countries**

**Unsafe surgery:**
- 0.4-0.8% permanent disability or death rate

**Blood safety**
- Countries implementing strategies for blood safety prevent the transmission of infections

**Developing countries**

**Unsafe surgery:**
- 5-10% permanent disability or death rate

**Blood safety:**
- Africa has highest rates of transmissible diseases through unsafe blood transfusion (8% hepatitis B, 2.5-10% hepatitis C)
Developed countries

Injection Safety:

• Injections used as necessary
• Single use of injection devices

Developing countries

Injection safety:

• In developing and transitional countries, 16 billion injections administered /year
• In parts of developing world 70% of injections are unnecessary (or could be given orally)
• Reuse of injection devices account for about 260 000 new HIV infections /year and 2,3 to 4,7 millions new cases of hepatitis B and C
Developed countries

Counterfeit drugs:

• In countries with effective regulatory systems incidence of counterfeit drugs is less than 1%

Developing countries

Counterfeit drugs:

• In many African countries, and in parts of Asia, Latin America, a much higher percentage of the medicines on sale may be counterfeit (can be as high as 77% of all reported cases).
Why does this happen

Hippocratic oath: '.... do no harm'

...is rarely voluntarily violated by health professionals, however every day patients are harmed during health care or suffer from not receiving the right treatment, (omission) in every country of the world
“Human beings make mistakes because the systems, tasks and processes they work in are poorly designed.”

Dr Lucian Leape, testifying to the US President’s Commission on Consumer Protection and Quality in Health
The Swiss Cheese Model:

**DEFENCES**
- Skilled staff
- Essential equipment
- Clinical policy
- Risk management plan

**THE GAPS**
- Inadequate staff knowledge
- Monitoring unavailable
- Interventions ill defined
- Poor handling of emergency
Issues: The 10 domains in developing countries in order of relevance

1. Health care associated infections (HCAI)
2. Preventable adverse drug events
3. Adverse events in mother and/or baby related to prenatal, labor and postnatal care period.
4. Adverse events due to surgical and anesthetic care
5. Adverse events related to wrong and/or late diagnosis
6. Adverse events related to injection practices
7. Adverse events related to unsafe use of blood and blood products
8. Adverse events related to medical device use
9. Patients falls and injuries due to falls
10. Pressure ulcers
RISKS TO PATIENT SAFETY

- Poor test follow-up
- Misdiagnosis
- Stress and fatigue of health care staff
  - Poor safety culture
  - Organizational/system failures
  - Inadequate use of protocols
  - Poor health system accountability
- Poor training of health care staff
- Workload pressures
- Poor patient identification
- Poor patient identification
Economic Impact of Unsafe Care

Medical errors

- USA: annual impact, $19.5 billion (2008)

Health care-associated infections (HCAI)

- Europe: 13-24 billion/year Euros (or an average of 25 million extra days hospital stay)

Medication errors:

- USA: annual impact, $ 3.5 billion (2006)
PATIENT SAFETY PROBLEM

"It also affects the lives of doctors, nurses and other health care staff who become the 'second victims' in a chain of events."

Sir Liam Donaldson
Former Chief Medical Officer  UK
WHO AND PATIENT SAFETY

2002: 55th World Health Assembly Resolution. MS requested WHO to build global standards and support MS

2003: Many countries started to implement patient safety initiatives and request WHO technical support

2004: Launch of the World Alliance for Patient Safety

2009: WHO Patient Safety Programme
WHO patient safety

The mission of WHO Patient Safety is to coordinate, facilitate and accelerate patient safety improvements around the world.

It provides a vehicle for international collaboration and action between WHO Member States, WHO’s Secretariat, technical experts, and consumers, as well as professionals and industry groups.
STRATEGIES FOR SAFER CARE

1. **Clean Care is Safer Care.** Strategies and tools to reduce health care-associated infection, through hand hygiene; government engagement, to support global and national hand hygiene campaigns.

2. **Safe Surgery Saves Lives Checklist** embedded in an implementation strategy to save lives by ensuring safe surgical practices are followed.

3. **Safe Childbirth Checklist** for ensuring safe practices during pregnancy and childbirth.

4. The **African Partnerships for Patient Safety** for building links between Africa and Europe to help tackle patient safety in Africa.

5. The **International Classification for Patient Safety** Framework for defining patient safety information linked to applying the Reporting and Learning systems to identify causes of risk and promote learning.
Research for better knowledge to make care safer, through establishing priorities, knowledge management, developing tools to assess harm and supporting research in developing countries.

Solutions for Patient Safety to translate knowledge into practical solutions.

Standardized patient safety protocols to achieve sustainable reductions in the occurrence of serious patient safety problems.

Patient Safety Curricula Guides to educate and train future health care workers as leaders in patient safety.

Patient for Patient Safety creating honourable partnerships between patients and the health care community and giving patients a voice.
CLEAN CARE IS SAFER CARE

• **Clean Care is Safer Care.** Strategies and tools to reduce health care-associated infection, through hand hygiene; government engagement, to support global and national hand hygiene campaigns.
Prevalence of nosocomial infections in the world

Developed countries

- Canada: 11.6%
- Scotland: 9.5%
- UK & Ireland: 7.6%
- Norway: 5.1%
- Finland: 9.1%
- Switzerland: 10.1%
- Greece: 9.3%
- Italy: 8.3%
- Cyprus: 7.9%

Range: 5.1-11.6%

http://www.who.int/gpsc/
Prevalence of nosocomial infections in the world

Developing and countries with economies in transition

Range: 5.7-19.1%

http://www.who.int/gpsc/
Surgical Site Infections incidence in Africa

Nigeria: 23.60% - 30.90%
Ethiopia: 21%
CAR: 18%
Uganda: 10%
Kenya: 19%
Tanzania: 19.40%

CAR: 14.80%
Kenya: 23.50%

Bagheri Nejad S et al. WHO Bull 2011
1: CLEAN CARE IS SAFER CARE

- Vision: Making infection prevention & control, with hand hygiene as the essential basis, a priority in health care everywhere

- Guidelines: Finalised and issued 2009


My 5 moments for HAND HYGIENE

1. Before touching a patient
2. Before clean/aseptic procedure
3. After body fluid exposure risk
4. After touching a patient
5. After touching patient surroundings

World Health Organization
1: CLEAN CARE IS SAFER CARE

122 Member States pledged to tackle HCAI

Jan 2011

42 Member States participate
WHO CleanHandsNet

Over 12,000 health care facilities from 122 countries registered for SAVE LIVES: Clean Your Hands

May 5 : Sign Up !
http://www.who.int/gpsc/5may/register/en/index.html
It is estimated that every year in the world 234 millions mayor surgery interventions take place

- 1 in every 25 people

It is estimated that 25% of hospital surgery presents some kind of complication

- 7 million complications per year

It is estimated that between 0.5 – 5% of all surgical interventions lead to death

- Approximately 1 million deaths per year
2. THE SAFE SURGERY SAVES LIVES STRATEGY

1. Creation of a checklist to improve the standards of surgical safety

### Surgical Safety Checklist

**Before induction of anesthesia**
- Has the patient confirmed his/her identity, site, procedure, and consent?
  - Yes
  - Not applicable
- Is the site marked?
  - Yes
  - Not applicable
- Is the anesthesia machine and medication check complete?
  - Yes
- Is the pulse oximeter on the patient and functioning?
  - Yes
- Does the patient have a:
  - Known allergy?
    - No
    - Yes
  - Difficult airway or aspiration risk?
    - No
    - Yes, and equipment/assistance available
  - Risk of >500ml blood loss (7ml/kg in children)?
    - No
    - Yes, and two IV/central access and fluids planned

**Before skin incision**
- Nurse Verbally Confirms:
  - The name of the procedure
  - Completion of instrument, sponge, and needle counts
  - Specimen labelling (read specimen labels aloud, including patient name)
  - Whether there are any equipment problems to be addressed

- To Surgeon, Anaesthetist and Nurse:
  - What are the critical or non-routine steps?
  - How long will the case take?
  - What is the anticipated blood loss?

- To Anaesthetist:
  - Are there any patient-specific concerns?

- To Nursing Team:
  - Has sterility (including indicator results) been confirmed?
  - Are there equipment issues or any concerns?

- Is essential imaging displayed?
  - Yes
  - Not applicable

**Before patient leaves operating room**
- Confirm all team members have introduced themselves by name and role.
- Confirm the patient’s name, procedure, and where the incision will be made.
- Has antibiotic prophylaxis been given within the last 60 minutes?
  - Yes
  - Not applicable

**Anticipated Critical Events**

**To Surgeon:**
- What are the critical or non-routine steps?
- How long will the case take?
- What is the anticipated blood loss?

**To Anaesthetist:**
- Are there any patient-specific concerns?
### Before induction of anaesthesia

- **Has the patient confirmed his/her identity, site, procedure, and consent?**
  - Yes
  - Not applicable

- **Is the site marked?**
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  - Not applicable

- **Is the anaesthesia machine and medication check complete?**
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- **Is the pulse oximeter on the patient and functioning?**
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- **Anticipated Critical Events**
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  - Yes
  - Not applicable

### Before patient leaves operating room

- **Nurse Verbally Confirms:**
  - The name of the procedure
  - Completion of instrument, sponge and needle counts
  - Specimen labelling (read specimen labels aloud, including patient name)
  - Whether there are any equipment problems to be addressed

- **To Surgeon, Anaesthetist and Nurse:**
  - What are the key concerns for recovery and management of this patient?
The list was piloted in 8 sites…

- **PAHO I**
  - Toronto, Canada

- **PAHO II**
  - Seattle, EU

- **EURO**
  - London, UK

- **EMRO**
  - Amman, Jordan

- **WPRO I**
  - Manila, Philippines

- **WPRO II**
  - Auckland, NZ

- **AFRO**
  - If Kara, Tanzania

- **SEARO**
  - New Delhi, India
### 2. CHECKLIST REDUCES DEATH BY 1/3

Checklist was tested in 8 pilot sites worldwide...

...and was found to reduce the rate of postoperative complications and death by more than one-third.

<table>
<thead>
<tr>
<th></th>
<th>Baseline</th>
<th>Checklist</th>
<th>P value</th>
</tr>
</thead>
<tbody>
<tr>
<td>Cases</td>
<td>3733</td>
<td>3955</td>
<td>-</td>
</tr>
<tr>
<td>Death</td>
<td>1.5%</td>
<td>0.8%</td>
<td>0.003</td>
</tr>
<tr>
<td>Any Complication</td>
<td>11.0%</td>
<td>7.0%</td>
<td>&lt;0.001</td>
</tr>
<tr>
<td>SSI</td>
<td>6.2%</td>
<td>3.4%</td>
<td>&lt;0.001</td>
</tr>
<tr>
<td>Unplanned Reoperation</td>
<td>2.4%</td>
<td>1.8%</td>
<td>0.047</td>
</tr>
</tbody>
</table>
Promoting PO technology as standard of care using WHO Checklist as entry point

Development of low cost Pulse Oximeter

Pilot testing
  - Use of a surgical checklist
  - Reduction of hypoxia time
  - Reduce morbidity and mortality

Building a procurement system
3. Safe Childbirth Checklist

A simple tool that aims to assist childbirth teams in assuring that all essential clinical practices are performed.

- Single Centre testing in Belgaum, India
- Preliminary findings suggest a significant improvement in a selection of key indicators:
  - Washing hands and wearing gloves when doing exam
  - Administering oxytocin 1 minute after
  - Using partograph for each labouring

- Study ongoing
- Larger study planned in all Regions
Mother and Baby Safer Care Tool

- Patient developed tool to help mothers recognize and act on danger signs post childbirth
- Paper version in development
- Mobile phone and voice recognition under development
4: AFRICAN PARTNERSHIPS FOR PATIENT SAFETY

Strengthens care delivery: situations analysis, identifying resources available, direct transfer of know-how from North to South and South to North
<table>
<thead>
<tr>
<th>1. Develop and implement national policy for patient safety</th>
<th>2. Improve knowledge and learning in patient safety</th>
<th>3. Raise awareness</th>
</tr>
</thead>
<tbody>
<tr>
<td>4. Address the context in which health services &amp; systems developed</td>
<td>5. Minimize healthcare-associated infection</td>
<td>6. Protect healthcare workers</td>
</tr>
<tr>
<td>10. Promote partnerships.</td>
<td>11. Provide adequate funding</td>
<td>12. Strengthen surveillance and capacity for research</td>
</tr>
</tbody>
</table>
Three Core Objectives
African Partnerships for Patient Safety

Objective 1: PARTNERSHIP STRENGTH

Objective 2: HOSPITAL PATIENT SAFETY IMPROVEMENTS

Objective 3: NATIONAL PATIENT SAFETY SPREAD
Step 1: Partnership Development
  • Welcome Letter
  • Welcome Pack
  • Webinar series

Step 2: Needs Assessment
  • Situational Analysis;
  • Improving Patient Safety – First Steps
  • Resource Map

Step 3: Gap Analysis
  • APPS Planning Framework;
  • Situational Analysis
  • Improving Patient Safety – First Steps
  • Resource Map

Step 4: Action Planning
  • Situational Analysis
  • Improving Patient Safety – First Steps
  • Resource Map

Step 5: Action
  • Action Plan;
  • Situational Analysis
  • Improving Patient Safety – First Steps
  • Resource Map

Step 6: Evaluation and Review
  • 6 monthly evaluation
  • Annual review

The APPS Approach – summary of the process
• APPS catalyzed national patient safety action in Ethiopia through advocacy, technical support and identification of national champions in the FMOH

• Ethiopian FMOH National Patient Safety Program established prioritizing 4 patient safety action areas in 3 pilot university hospitals (activities supported by collaborative efforts of health NGOs).

• The situation in Ethiopia is not unique...can be replicated elsewhere in Africa.
Situational Analysis

- A structured tool for collecting baseline assessment information;
- Yes/No approach;
- Long and a short version;
- Identify gaps/areas of focus via Short Form;
- Use Long Form for more detailed information on key patient safety areas
Patient Safety Resource Map

African Partnerships for Patient Safety (APPS) Working for safer health care... together

African Partnerships for Patient Safety
Resource Map
Prototype version 1
English
April 2010
6. PATIENT SAFETY RESEARCH

"Better knowledge for safer care"

Objective: to facilitate the spread and use of research findings to inform safer health care worldwide through:

- Unveiling the problem of unsafe care and raising awareness
- Providing guidance and tools regarding patient safety research
- Strengthening capacity for research
- Evaluating effectiveness of PS measures
6. PATIENT SAFETY RESEARCH:

Unveiling the problem of unsafe care and raising awareness:

Country studies

The Eastern Mediterranean and Africa study is the result of a collaboration between the ministries of health of Egypt, Jordan, Kenya, Morocco, Sudan, Tunisia, Yemen, the Council of Accreditation of Health Care Organizations (COHSASA) in South Africa and the WHO Regional Offices for the African and the Eastern Mediterranean Regions. The study covering the American Region is the result of a collaboration between the ministries of health of Argentina, Costa Rica, Colombia, Mexico, Peru, the Ministry of Health and Social Protection of Spain and the Pan-American Health Organization.
For the Study conducted in Africa

• Out of all cases, 8.2% of admissions were associated with an Adverse Event during hospitalization.

• 24% of these cases suffered permanent disability or death as a consequence of the adverse events.

• Admissions with Adverse Events incurred an additional 6.5 bed days.

• More than 50% of the Adverse events were determined to be highly preventable.
## 2. Guidance and tools: Priorities

<table>
<thead>
<tr>
<th>Developing countries</th>
<th>Countries in transition</th>
<th>Developed countries</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Strong emphasis on applied and evaluative research leading to the development of local cost-effective solutions</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>1. Counterfeit &amp; substandard drugs</td>
<td>Inadequate competencies &amp; skills</td>
<td>Lack of communication &amp; coordination (including coordination across organizations, discontinuity &amp; handovers)</td>
</tr>
<tr>
<td>2. Inadequate competencies &amp; skills</td>
<td>Lack of appropriate knowledge &amp; transfer</td>
<td>Latent organizational failures</td>
</tr>
<tr>
<td>3. Maternal &amp; newborn care</td>
<td>Lack of communication &amp; coordination (including coordination across organizations, discontinuity &amp; handovers)</td>
<td>Poor safety culture &amp; blame-oriented processes</td>
</tr>
<tr>
<td>4. Health care-associated infections</td>
<td>Health care-associated infections</td>
<td>Inadequate safety indicators</td>
</tr>
<tr>
<td>5. Unsafe injection practices</td>
<td>Maternal and newborn care</td>
<td>Adverse drug events due to drugs &amp; medication errors</td>
</tr>
<tr>
<td>6. Unsafe blood practices</td>
<td>Adverse events due to drugs &amp; medication errors</td>
<td>Care of the frail &amp; elderly</td>
</tr>
</tbody>
</table>
2. Providing guidance and tools to measure harm

- Retrospective record review
- Record review of current in-patients
- Staff interview on current in-patients
- Nominal group technique
- Direct observation and related interviews
You are invited to join an online webinar on
18 October 2011 from 12:00 to 13:30 (GMT)
(The webinar will be held in English)

To present and discuss the WHO Patient Safety recently released guide:
Assessing and tackling patient harm:
A methodological guide for data-poor hospitals

WHO Methodological Guide - Interactive Webinar

This guide is meant to be used by researchers, quality managers, clinicians and other professionals with an interest in understanding and tackling patient safety concerns in hospitals, without needing to rely on good medical records. The guide comes with a set of supporting materials, such as PowerPoint presentations to train health professionals who will be implementing the protocols and presentations to be used to inform different stakeholders about the different studies. During this session explanations of how to use this guide, the guide contents and practical advice for conducting the different methods will be given.

*Featuring a question and answer session at the close of the webinar.*

Please register here for this webinar before 10 October 2011:
https://extranet.who.int/datacol/survey.asp?survey_id=1880
Username: guest; Password: guest

Contact information: pslearning[AT]who.int, (please replace [AT] with @)
Stimulating research to make care safer

WHO Patient Safety Research Small Grants

Established in 2008 to:

- Stimulate patient safety research through seed funding of up to US$ 25,000 per grant
- Strengthen local capacity for patient safety research
- Promote the culture of patient safety by facilitating research dissemination and utilization.

Objectives:

- Stimulate new local research
- Strengthen local research capacity
- Raise awareness & promote safety culture

Outputs:

- Locally owned & relevant data
- Strengthened dissemination & utilization

Expected Outcomes:

Evidence-based
- Decision-making
- Practices
- Policies

Safer Health Care
WHO Patient Safety Research Small Grants

Countries where research is being conducted

Key achievements:
Supports 25 research teams in 22 countries, generating 25 locally relevant studies.

Research Topics:
- Epidemiology of adverse events
- Medication safety
- Hand hygiene and infection controls
- Patient safety culture
- Safe surgery
- Patient engagements.

Empowering five first-time principal investigators
Enabling five researchers to become doctoral graduates
Promoting networks and collaborations
Raising awareness of patient safety by engaging decision-makers
Empowering frontline providers to deliver safer care.

World Health Organization
Patient Safety
A World Alliance for Safe Health Care
Small grants in Sub-Saharan Africa

Patient safety culture in health facilities in Ghana

Impact of disposable glove use on the health-care workers' compliance with hand hygiene during care. Mali

Impact of hand hygiene and disinfection of stethoscopes on the potential of health care-associated infection transmission by stethoscopes in Nigeria

Situational analysis of injection practices in health care. Uganda

Molecular residual risk of transfusion transmitted viral infections in pre-transfused blood in Tanzania

Effectiveness of health education intervention on the documentation and reporting of adverse medication events in a Nigerian teaching hospital

A comparison of medical records review and incident reporting for in-patient adverse event assessment. Kenya
Solutions aim at redesigning care processes to prevent harm to patient.

Useful tool to raise awareness and commitment by decision makers to patient safety

WHO designated the Joint Commission Intl. as the Collaborating Centre on Patient Safety to develop the Solution Aide Memoires.

9 solutions Aide Memoirs developed and released in 2007:
- Look-Alike, Sound-Alike Medication Names
- Patient Identification
- Communications During Patient Handovers
- Performance of Correct procedure at Correct Body Site
- Control of Concentrated Electrolyte Solutions
- Assuring Medication Accuracy
- Single Use of Injection Devices
- Avoiding Catheter and Tubing Mis-Connections
- Improved hand hygiene

One solution developed in 2008
- Preventing Central Line-Associated Bloodstream Infections
The project seeks to “bring local variations in health care practice into a global ideal of patient safety” by developing standardized protocols that can be applied in any hospital, anywhere in the world.

Three SOPs:
- Managing Concentrated Injectable Medicines (Heparin, Morphine, KCl)
- Medication Accuracy at Transitions in Care
- Performance of Correct Procedure at Correct Body Site

Detailed evaluation framework and data collection tools: to evaluate protocols and see improvements in the risks they address.
9: PATIENT SAFETY CURRICULM GUIDE

2009: Launch of the Patient Safety Curriculum Guide for Medical Schools

2010: Evaluation of Curriculum Guide for Medical School in 12 pilot sites (9 countries)


2011: Launch of Multi-professional Patient Safety Curriculum Guide
Objective: Strengthen health systems by educating future healthcare professionals in patient safety

- **PS Multi-professional Curriculum Guide:** developed to engage faculty and introduce Patient Safety topics to medical, nursing, midwifery, dentistry and pharmacy students.

- **Part A: Teacher’s Guide**
  - Designed to build capacity for patient safety education and programme planning and design.

- **Part B: 11 topics/modules on patient safety**
  - Flexible, adaptable to country universities - can enter at any stage
  - Complete curriculum or use selective topics on case by case basis
10. PATIENTS FOR PATIENT SAFETY

- Recognize the essential role and value of patient involvement as a catalyst for change
- PFPS works with a global network of patients, consumers, caregivers, and consumer organizations to support patient involvement in patient safety programmes, in countries and globally. (214 Champions)
- Champions have been very successful in raising awareness.

Patients influencing policy & practice – stories that make a difference

- Raising awareness of patients' rights; developed patient charter, endorsed by MoH and displayed in facilities nationwide
- Changing culture; influencing medical students through the experience of losing her son due to a series of errors.
PFPS Champion Activity

Activities
- Patients Organizations
- Training Courses
- Media Campaigns
- Networking
- Journal Articles
- Patient Materials

Committees
- Health quality and hospital boards
- Health ministries
- WHO expert committees

Presentations to
- Healthcare workers
- Medical Students
- Patients
- Hospital boards
- National groups
- Health Ministers
Patient Safety in the African context
Patient Safety situation in Africa

In the African region, most countries lack national policies and plans on safe and quality health-care practices.

Inappropriate funding of health care systems, unavailability of critical support systems including strategies, guidelines, tools and patient safety/quality of health care standards remain major concerns in the Region.

Weak health care delivery systems including sub-optimal infrastructure, poor management capacity and under-equipped health facilities have brought about a situation where the likelihood of adverse events is high.

The overuse, underuse or misuse of medicines: black market medicines, medicines in the streets, counterfeit…

A lack of adequate infection control within health care facilities
Unsafe surgical care: very few countries in the Region systematically use the safe surgery saves lives check-list recommended by WHO.

Serious risk of infection from blood borne pathogens and other infections such as TB for health-care workers including lab personnel;

Implementation of blood safety remain an important challenge in the Region

Shortages of human resources, low level of staff preparedness and lack of continuing medical education

Lack of partnership involving patients and civil society in improving patient safety

Inadequate data on patient safety issues.
The challenges of patient safety in developing countries including African countries

- Patient Safety is a new concept not always easy to understand
- Patient Safety is not seen as a priority when health systems are faced with other pressing health issues
- There is a blame culture which leads to occultism
- Often there is a fatality mentality… Things are like this here!
What is WHO PS Programme proposing

Simple solutions that make a change!
- Hand washing, checklists, protocols, standard procedures, local solutions.

Change in Patient safety culture
- Communication, Leadership, Learning from errors. Commitment

Integrate patient safety into all aspects of Health care
- Patient safety as a crosscutting issue

Integrate Patient Safety into training curricula of health professionals
Local production of ABHR according to the WHO formulation: Cost: 0.30 $US/100 ml
Commitment of ministerial and hospital authorities (Mali)
Step 3: Distribution of the WHO formulation to all HCWs
Can it be done? Michigan, USA

Reductions in ICU catheter-related blood stream infections across the whole State of Michigan USA

The work of Professor Peter Pronovost’s team at Johns Hopkins University Hospital
Thank you very much for your attention