World Health Organization | Patient Safety
A World Alliance for Safer Health Care

Patients for Patient Safety News
August 2009

Welcome to the August 2009 PFPS Newsletter! This edition is packed with information on champion activities, featuring a recent in-country workshop in Australia, Champion involvement in WHO Patient Safety meetings, and the first regional Safe Surgery Saves Lives meeting in Jordan.

Australian PFPS Workshop

The first Australian Patients for Patient Safety Workshop took place in Perth, Western Australia from July 7-9 2009. Forty health consumers, many of whom had experienced harm in health care, health providers and policy makers came together for three days to share their experiences, build partnerships, and develop strategies and action plans for taking patient safety forward in Australia.

On the first day of the workshop, within a safe, nurturing space, participants shared what had brought them together. Each participant spoke of how they had experienced harm in health care or how they had witnessed errors occur to patients. Participants spoke of what they had done to provide solutions to ensure that systems were changed so that the error did not happen again to someone else. In addition, they spoke about what their hopes were for the future for patient safety in Australia.

> ***"…I read sad stories every week…its very powerful to see the faces behind the sad stories…if you have the strength to tell your story…its more powerful than anything …I will go home to lobby this cause forward..."*** Health provider

On the morning of the second day participants were oriented to WHO Patient Safety and Patients for Patient Safety. In the afternoon in small groups participants worked enthusiastically on key topics in patient safety and developed strategies and action plans to take patient safety forward.

On the third day these strategies and action plans were further developed and presented back to the Group. These included strategies and action plans for culture change to learn and prevent health care errors, for capacity building for patients and health providers to work in partnership for solutions to health care harm together, by establishing a formal network of people committed to patient safety.

One of the key outcomes from the workshop was the development of the Perth Declaration for Patient Safety, the participants collective call to action and vision for the future of patient safety in Australia. The Perth Declaration for Patient Safety was officially launched on August 5, 2009 at Parliament House in Perth. The Declaration is a collective call and commitment to make Patient Safety a priority within all areas of health care, to prevent health care harm, to ensure our experience informs positive change and to advance patient safety in partnership for co-creating safer care.

> **"…*The first day really drained me and had such an impact hearing other people's stories. I wasn't alone … I felt alone when my adverse event occurred but we are not all by ourselves …It's not just us alone … there is friendship and commitment together here with us all and the health professionals…"*** Health Consumer

A look inside…

Continued on page 2…

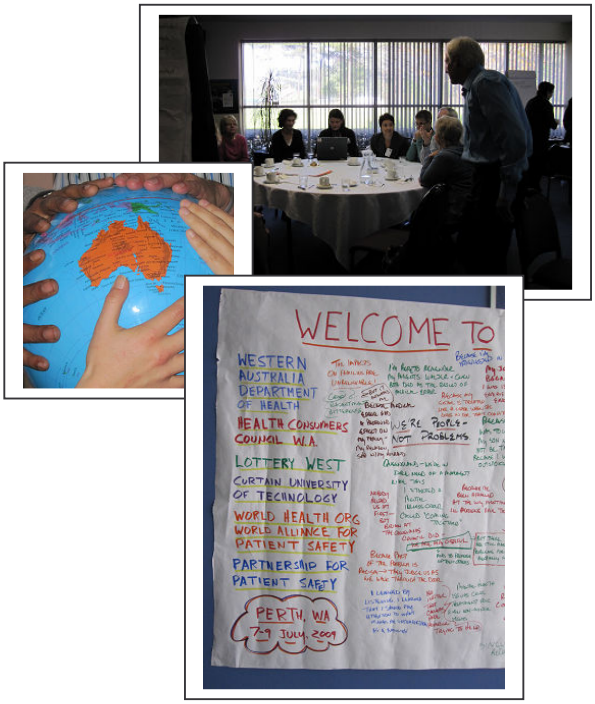
Editors: Sue Sheridan, Expert Lead / Pat Martin, Internal Lead / Anna Lee, Project Support leea@who.int

More news from the Australia

Continued from page 1…

The Inaugural Australian Patients for Patient Safety Workshop was a collaboration between WHO Patient Safety – *Patients for Patient Safety,* Health Consumers Council WA, Western Australian Department of Health – Office of Safety and Quality in Health Care and Curtin University of Technology, Partnerships for Patient Safety and Patients for Patient Safety global champion Stephanie Newell, from Australia. Funders for the event included all Western Australian workshop partners, Lotterywest WA and the Australian Commission on Safety and Quality in Health Care. Participants from the Australian states of Victoria, Queensland and South Australia were funded by their respective State Government Department's of Health.

"…Being a policy maker I leave here with a great sense of responsibility to make change across primary care … I have a tangible reason to make change for improvement…" Policy maker



Personal Experience

Stephanie Newell, Patients for Patient Safety Champion, Australia

The last four weeks have been a most amazing and inspirational time for me. My long held aspiration and dream of holding the first Patients for Patient Safety Workshop here in Australia became a reality. Over the three days of the Workshop I was continually humbled by the participant's courage and generosity of spirit in sharing their experience of health care harm and I was motivated by their energy, drive and powerful commitment to partnership in patient safety for lasting change. It was a privilege to witness the participants consider one another's perspectives, build partnerships and work together on solutions, considering the principles of patient safety, to make a lasting impact for safer care.

The last four weeks have also been a most amazing, transformational and crucial time for Patient Safety in Australia. For the first time in Australia, the Patients for Patient Safety Workshop provided a forum and environment with a pure focus of honouring the perspectives of those people who have experienced harm in health care, ensuring all perspectives of those around the table are heard, developing proactive working partnerships for future plans for tangible solutions for Patient Safety. The Patients for Patient Safety workshops' model and concept of bringing people from the different dimensions of health care - health consumers, health providers and policy makers together to the table to focus on patient safety solutions in partnership has meant that Australia has now entered into a new dimension for patient safety.

A major first step in paving the way for innovative and robust change and improvement in patient safety is the Perth Declaration for Patient Safety. The Declaration is the foundation for solid progress to be built upon as we move into an exciting new future of change for Patient Safety. The Perth Declaration for Patient Safety embodies the experience, wisdom and vision of committed change agents in patient safety.

The energy, passion and need for improvement that brought people together to the Patients for Patient Safety Workshop, shaped partnerships, developed bold plans for the future and created the Perth Declaration for Patient Safety, now continues as each Workshop member takes the energy, passion and commitment forward, builds the vision and co-creates a safer health care system.

For more information email Steph at stephnewell@hotmail.com

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EMRO

EMRO Safe Surgery Saves Lives meeting

An EMRO regional Safe Surgery Saves Lives meeting was held on 22 June in Jordan. Inaugurated by the Minister of Health, Jordan and the WHO EMRO Regional Director, representatives from all but two countries in the region attended. Dr Atul Gawande gave the keynote address, and presentations followed from WHO HQ / EMRO, Health Care Accreditation Council (HCAC), Jordan, among others as well as presentations from countries in which the Safe Surgery Initiative was pilot tested or implemented.

Checklist implementation in an Egyptian Hospital

Mahmoud el Damaty, Patients for Patient Safety Champion, Egypt

The Sharq Al-Madina Hospital faced many events that drew the attention for the great need to implement the Surgical Safety Checklist, such as adverse events and near misses. The following indicates the steps that were taken in implementing the Surgical Safety Checklist at the Sharq Al-Madina Hospital in Alexandria.

First a 'critical mass' group was created, which consisted of staff with the right mix of skills and motivation to take on this task. WHO had recommended that one person be responsible for implementing the checklist, but we found in our hospital this lead to antagonistic relationships with other members of the operating room. Therefore, we formed a team of anaesthesiologists and / or nurses. We selected individuals that had good relationships with everyone, and good communication and negotiation skills.

The checklist was then modified in the following ways in order to be best suited to implementation at the Sharq Al-Madina Hospital;

- Within the sign-in stage, a section was added to include the patients name and date of birth as two identification tools.
- It was decided sign-out should be made before the closure of the patients wound, rather than before the patient leaves the Operating Room.
- Another section was added to allow for signatures of individual members of the operating team (ie, anaesthesiologist, surgeons, scrub nurse etc)
- The open-cardio thoracic surgical team designed their own checklist
- It was agreed that sign-in should occur in the Open Heart ICU which is close to operation theatres.

There was some opposition to the implementation of checklist, some feeling it was a waste of time, an added frustration to the workload. The main causes of the opposition was a lack of knowledge, and a natural instinct to resist change.

We decided the way to overcome this resistance, was by ensuring top management involvement and commitment, creating awareness by sharing knowledge, the setting of goals and priorities, convincing people on an individual basis and getting the individuals opposed to the checklist, involved in its implementation.

First the checklist was only implemented in one operating room (general surgery) and was then extended to three further theatres (to include general surgery, special surgery and open heart surgery) plus an emergency operating room. Posters of the checklist have been displayed in all theatres and after surgery a hard copy of the completed checklist is attached to each surgical case medical record.

The benefits of implementing the checklist include increased safety of patients, ethical considerations, efficiency, effectiveness, efficacy, continuity, appropriateness and legitimacy and this therefore results in the improvement of the hospital image and reputation.

For more information email Dr Damaty at mmdamaty@yahoo.com

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Other Champion News

Technology Meeting

Sara Yaron, Patients for Patient Safety Champion, Israel

For the past year a group of about 20 professionals from all over the world, including 2 PFPS Champions, have been studying and researching Technology and Patient Safety, under the umbrella of WHO, in order to publish an article.

The group was divided into 4 subgroups, each one being responsible for researching all relevant literature about one of the subtitles, and to write up a review.

We had 3 international teleconferences, in which we discussed questions and dilemmas which arose during the writing of our reviews.

In May 2009 a one day meeting was held in London at Imperial College, and most of the group were able to take part. In that meeting, each subgroup represented their review, while the other members of the group gave feedback.

The final article will be edited by Dr. Rajesh Aggarwal from the Imperial College London, and Professor Stuart Whittaker, Chief Executive Officer of The Council for Health Service Accreditation of Southern Africa, and it is hoped it will be published in a professional journal.

For more information please email Sara at yaron-i@bezeqint.net

Regional Health Forum, Poland

Jolanta Bilinska, Patients for Patient Safety Champion, Poland

A regional health forum held in Poland on 8 July for over 70 members of the health care system, resulted in the signing of a 'Safe Hospital, Safe Patient' Declaration. The Declaration emphasizes the importance of involving patients in the decision making process around diagnosis and treatment, the necessity to run a hospital and its medical staff efficiently, and the need to educate patients in health problems and for better communication between doctors and patients.

"Safe hospital, safe patient" Declaration

1. **Effective hospital management and initiation of accreditation standards and ISO standards increases patient and medical staff safety.**
2. **Patient safety depends on a proper level of medical services. Hospital staff attempts to broaden their medical knowledge and apply generally accepted treatment standards.**
3. **The staff attempts to educate patients in health matters, remind them about prophylactics, which prevents illnesses and reduces costs of treatment.**
4. **In a safe hospital sanitary and epidemiological rules are observed.**
5. **Proper patient-personnel communication – involving the patient in decision making process about diagnosis and therapy – makes the treatment easier.**

The theme of the conference was 'Patient Safety in the health care system in Poland – challenges and achievements', and participants included medical and legal representatives, NGOs and patients.

The honorary lecturer was Vice Minister of Health, Mr Adam Fronczak, who presented the assumptions of the Act of 21 May 09, on individual and collective patients' rights which places the Commissioner for Patients Rights as the central authority protecting patients rights.

During the forum, many issues were discussed such as patients claims and compensation for damages to patients in Scandinavian countries and in France. Attendants were also interested in the role of communication between a patient and medical staff, and in medical information as the basis for the commencement of treatment. Doctor's duty is to convey a message clearly and reliably so that the patient can make an informed decision.

For more information email Jolanta at j.bilinska@nfz-lodz.pl

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WHO Patient Safety

Safe Childbirth Checklist Meeting

Clair Lemer, Clinical Advisor, Safe Childbirth Checklist

On 8 and 9 July, WHO Patient Safety convened an international meeting of experts in Geneva to address the possibility of developing a checklist that would help to ensure the delivery of minimum care standards to mother and baby around the time of childbirth. Meeting delegates came from diverse backgrounds with expertise in advocacy, academia, frontline experience, and newborn and maternal health. Representatives were present from all WHO regions. The meeting was further advanced by the extensive support of WHO colleagues.

Following a detailed discussion regarding the transferability of the checklist concept to childbirth there was clear consensus that such a path was feasible, practical, and necessary. Technical groups started the work of defining potential "pause points" - steps in care at which detection and correction of error, or preventive action, could be associated with a significant reduction in harm. An early draft Safe Childbirth Checklist was populated, with the major causes of maternal and neonatal mortality used as starting points.

The draft checklist developed in Geneva is now going through a dynamic process of revision according to comments raised by meeting participants and other experts. Informal testing will help to inform additional modifications. When a 'final' draft is agreed upon, more formal testing will be vital to evaluating its efficacy.

PFPS representatives, Susan Sheridan and Barbara Farlow participated in this meeting. Below Barbara has shared her experience.

Barbara Farlow, Patients for Patient Safety Champion, Canada

It was a privilege and honour to be invited to be part of the Safe Childbirth Checklist meeting in Geneva at WHO headquarters on July 8 and 9.

Sue Sheridan and I were the patient/family member representatives in the meeting which consisted mostly of approximately 40 renowned neonatologists, obstetricians and midwives from around the world. Dr. Atul Gawande was the amazing moderator and leader of the group, with Dr. Jonathan Spector from Boston assisting.

The goal was to review and prioritize the leading causes of maternal and neonatal death. The challenge was to reduce the critical elements that lead to avoidable deaths onto a one-page checklist.

The majority of the group members have extensive experience working with developing countries where most of these deaths occur. Their contributions and insights were invaluable. I could not help but stop and reflect how phenomenal and historic an event it was to witness the incredible knowledge in the room coming together and being effectively condensed onto a single page that would ultimately save thousands of lives. As a result of the personal experience of having lost a baby myself, I know the impact that each and every one of the lives that will be saved will have on families.

A first draft of the checklist is now being reviewed and will soon be tested. Stay tuned for further developments!

For more information on this article email Barbara at b_farlow@hotmail.com

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2009 WHO Patient Safety Small Grants Research Programme

Applications are invited for the second round of funding for the 2009 Small Research Grants Programme. The programme provides grants to small research teams with the aim to stimulate research and build research capacity on patient safety issues around the world. Applications will close on 30 September 2009.

Objectives of the initiative

- To increase research on patient safety by providing seed funding for 20 – 30 small research projects per year
- To contribute to building local capacity for research on patient safety by providing grants to research institutions and research teams in developing countries and countries with economies in transition, especially for projects in which young researchers and those in early or mid career are the lead investigators
- To promote the culture of patient safety by improving dissemination of research findings to the global community

The programme focuses on applied research. Applications that attempt to identify local solutions, or evaluate the effectiveness and cost-effectiveness of existing solutions are especially welcomed.

For more information click the link below; www.who.int/patientsafety/research/grants/en/index.html

New Brand for WHO Patient Safety

The World Alliance for Patient Safety has a new image, brand and style guide which reflects the increasing range of patient safety work being achieved internationally. Most importantly, we will now be using the name "WHO Patient Safety" to refer to ourselves. Patients for Patient Safety have a new colour within the palette range as you can see from this newsletter. We hope you like it.

Changing the brand sends a strong message that patient safety is an integral part of the World Health Organization and contributes to its vision and mission through the work that is being undertaken globally. At the same time, the strapline of 'a world alliance for safer health care' gives continuity to the original name and maintains our profile.

Every programme within WHO Patient Safety now has a specific colour and there are guidelines about their use. A defined brand contributes to the image of any organisation and it is important for our credibility that we use this in the best possible way. As the website is updated (which is happening over the next few months), the different colours will be more visible and will contribute to promoting the different action areas underway in patient safety.

Next time…

The next edition of PFPS News will be sent out in November, and will include articles from the Clean Hands, Save Lives meeting, PFPS in-country workshops in Mexico and Denmark, along with initial findings from the Patient Engagement and Surgical Safety Tool Development Survey. If you have any news to share please send through contributions to leea@who.int before 25th October 2009.

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