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

Patients for Patient Safety News
November 2010

Welcome to the latest edition of PFPS News, which features highlights from the ISQua Conference in Paris, PFPS Champion activities in Egypt, Ireland and Mexico, and much more!

Communicating Radiation Risks in Paediatric Imaging

Susan Sheridan, Patients for Patient Safety Expert Lead, was invited to participate in a WHO meeting on Radiation Risk Communication in Paediatric Imaging, from 20 to 22 September 2010, at WHO headquarters, Geneva.

The use of paediatric imaging is rapidly increasing worldwide, largely as a result of the increase of paediatric computed tomography (CT). Imaging has become an increasingly important component of the clinical evaluation of paediatric patients and technological advances are making non-invasive evaluation of a wide range of paediatric diseases possible.

Like all medical procedures, radiological medical procedures present both benefits and risks. Therefore, a balanced approach is needed that both recognizes the multiple health benefits that can be obtained from the use of radiation in medical imaging, while addressing and minimizing health risks.

Due to the radiation risks associated with CT, attention has focused on using alternate imaging methods without ionizing radiation exposure. Ultrasound and magnetic resonance imaging (MRI) do not involve ionizing radiation and are often preferred for the paediatric population.

Radiation protection of children is a priority for the WHO Global Initiative on Radiation Safety in Health-Care Settings and the meeting was held to develop the first draft of a toolkit for health care providers on radiation risk communication in paediatric health care. It is hoped the tool will also provide consumers with information, resources and advice on understanding the radiation risks of paediatric imaging.

> Risk communication is an interactive process of exchanging information and opinion among those responsible for assessing, minimizing and controlling risks and those who may be affected by the outcomes of those risks.

The meeting gathered radiologists, paediatricians, family doctors, radiographers, nurses, regulators, researchers, communication experts and representatives from relevant international organizations. Susan Sheridan was invited to the meeting to bring the consumers' voice and share the patient perspective on this important issue. Susan emphasized the need for joint decision-making regarding paediatric imaging. This should be enabled through honest communication with parents of the potential risks involved, the empowerment of patients and families to ask the key questions regarding alternate options to CT, such as MRI and ultrasound, and by encouraging patients and families to be aware of the tracking of cumulative effects of CT scans.

For more information on this meeting email psheri9110@aol.com

Look inside:

PFPS Champion Activities

Mexico Network

Evangelina Vazquez Curiel, PFPS Champion, Mexico

The last few months have been very exciting and we are working hard in several hospitals. We have been making new partnerships with health professionals in hospitals in Mexico City, Guadalajara, Jalisco and Monterrey, working on different activities, including promoting open disclosure, patient and family-centred health care and prevention of maternal deaths, as well as the use of the WHO Surgical Safety Checklist.

We are currently preparing a venture on the prevention of maternal deaths with Hospital de la Mujer (Women's Hospital). The Nursing Department of this hospital is promoting the project in connection with the Mexican Network of Patients for Patient Safety in order to reinforce this work. The participation of mothers and fathers is also being promoted through workshops and other activities.

At the National Medical Centre November 20th, the haematology and paediatric oncology health team worked with the families on developing strategies of collaboration regarding patient safety. One of those strategies is to focus on parents taking a record of the attention given to their children as a way of collaborating and improving patient safety. We have run workshops to formally start the programme.

For more information on this meeting email curiel@servidor.unam.mx

Signs of Change?

Rebecca O'Malley, PFPS Champion, Ireland

Over the last few months my Irish PFPS colleagues, Margaret Murphy, Mary Vasseghi and I have noted that some aspects of the Irish health service may be changing for the better. This has been demonstrated by what seems to be an increased level of engagement with patient advocates.

Over the last year, each of us has been invited to be the patient advocate, or 'service user representative' as we are often called here, in different Health Service Executive (HSE) and Department of Health and Children working parties. The work of some of these has concluded, others are ongoing but we each feel that, as patient advocates, we have made valuable contributions and brought a perspective to the decision-making process that had been missing up to now.

Just before the summer, we were invited to meet with senior members of the Department of Health and the HSE to discuss setting up a National Network of Advocates. At the moment, we are the only PFPS Champions in Ireland, but the need for more Champions is becoming apparent as the desire for an increased level of patient engagement appears to be rising.

In October, we were also invited to meet with the newly appointed Chairman of the HSE and had a round table discussion with him that allowed us to put forward our vision of a health service that works more in partnership with its patients and engages with them at all levels of decision-making. At the end of the meeting, we were invited to return annually during his 5-year tenure for further discussions.

Also in October, Mary, Margaret and I were invited, together with others drawn from a wide spectrum of interests and expertise, to a consultation meeting hosted by the Department of Health and Children on the subject of Performance Framework Indicator Sets. We understand that this is the first time that the Department has held such a consultation meeting.

We are very pleased with this increased patient engagement at such a high level and gladdened to see things going in the right direction. Watch this space!

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Outpatient Parenteral Antibiotic Therapy

Graham Tanner, PFPS Champion, UK

Graham Tanner has been working in collaboration with National Concern for Healthcare Infections and the British Society for Antibiotic Chemotherapy to develop and expand the provision of Outpatient Parenteral Antibiotic Therapy (OPAT) services throughout the UK.

OPAT can be delivered for many clinical indications, with an important area being the delivery of community/home antibiotic therapy connected with wound infections such as MRSA and other skin and soft tissue infections.

Patients would be clinically assessed for discharge and consulted about the therapy (medication, including possible side-effects; dosage and frequency of dose; stop date and re-assessment procedure).

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PFPS Activities in the East of England

Peter Metherall, PFPS Champion, UK

After becoming a PFPS Champion in 2008, I have developed interests in several fields of patient safety. As a member of the Patient Safety Committee and the Safer Medication Committee at my local hospital, I became involved with the Venous Thromboembolism (VTE) awareness campaign, serving on the East of England Strategic Health Authority's Clinical Board for Patient Safety and the Acute Trust's VTE Steering Committee. We had a launch of 'Stop the Clot' campaign where I gave a presentation. Among other measures a strategy was developed of risk assessments for all patients and the hospital pharmacist worked hard to incorporate these assessments into the drug charts. We launched the new measures in August 2010.

I feel patient safety in hospitals in England has made great strides with the improvement of these assessments for all hospital patients for VTE; the measures for reducing cross-infection in hospitals; the Hand Hygiene campaign; Nutrition; Hydration; Prevention of Pressure Sores; Administration of Medication; Prevention of Slips, Trips and Falls; Patient Identification and the Monitoring of each patients' progress through regular observations.

I have always thought that patients should take some responsibility for their care while in hospital. With this in mind, our Patient Safety Coordinator, in consultation with many hospital staff, produced an A4 illustrated card showing the main areas of care patients should expect to receive in hospital. With this detailed information about each category, it will enable them to ask questions to their doctors and nurses. I really feel that this card is the answer to many problems that both patients and staff may experience under the umbrella of 'patient safety'.

Here at Bedford Hospital we have just had our first Patient Safety Matters Open Day. This was held in a public area of the Hospital and open to all staff, patients, relatives and visitors. We launched our Patients' Safety Card, which will be given to every patient on entry to the hospital (see right), and this was on display. The aim was to showcase patient safety initiatives at the hospital, and it was deemed a success.

As an added bonus, I was presented with an award by the Deputy Medical Director and Patient Safety Coordinator at the Patient Safety Matters Day for Outstanding Contribution to Patients' Safety.

I feel privileged to have had so much input into improving patient safety and being so closely involved with my local hospital, the Regional Area Health Authority and WHO, and meeting the professionals has given me an insight into both sides of the issues that all hospitals and patients have to cope with in these modern times when expectations from patients are so high.

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Ideally the health care provider would arrange for intravenous therapy in a community setting, out-patient clinic or in acceptable circumstances a patient's home. In some instances the patient or their carer, following detailed training, might prefer personal administration of their medication. Contact telephone numbers would be made available to patients to discuss any areas of concern which might occur and importantly patients and GPs would be provided with medication reconciliation records at the point of discharge.

Therapy in a community or home environment has a number of advantages for patients – control over the administration of their medication; enhanced patient dignity and privacy (no commodes, etc), freedom from social isolation (recent studies indicate that being with family and friends can enhance recovery), reduced risk of psychological problems associated with boredom, improved nutrition and hydration, reduced risk of pressure ulcers, less sleep deprivation and less risk of contracting other infections.

There are also considerable advantages for hospitals – reductions in patient bed days provides greater space availability at a time of growing demands of an ageing population; effective and productive health care which produces economic effectiveness at a time of financial constraint.

The initiative provides evidence of what can be achieved when patient groups and health-care professionals work in collaboration to provide the best possible health care for patients.

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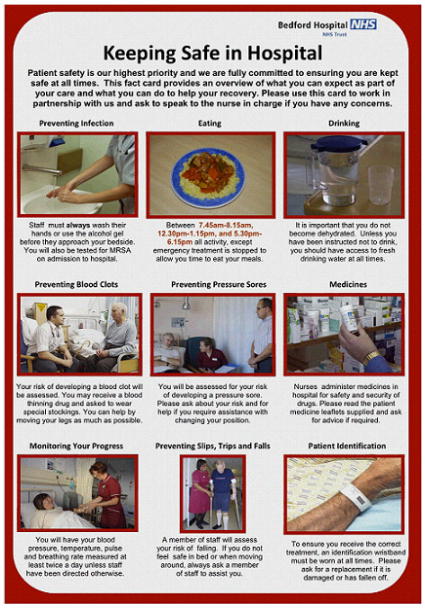

Activities in Egypt

Nagwa Metwally, PFPS Champion, Egypt

Our group in Egypt has continued to observe safety levels in the Einshams hospital and contribute to sharing possible solutions with the hospital management. However we are now expanding these activities in other hospitals, after they heard of our initiative and requested our assistance.

I have also been asked to participate and share experiences at more meetings, the voice of the patient is being recognized and invited to speak up more and more, and there are also an increasing number of meetings working towards quality in health care in the Middle East.

In October, I attended the Spice Conference in Cairo in collaboration with the French Society of Infection Control, and I talked about the WHO Surgical Safety Checklist. After the presentation, many participants were interested and asked for copies of the checklist, and what made me happy is that many of these were from different hospitals and universities, outside of Cairo, and were not those we normally work with.

Finally, another important activity this month was my meeting with the director of the hospitals of Einshams. I discussed concerns around patient safety from our observations and he agreed to make changes, so I will follow up with him. **For more information email nagwa0@gmail.com**

ISQua 2010

Quality Outcomes: Achieving Patient Improvement

Delegates from 67 countries met in Paris between October 10-13 for the ISQUA conference. A number of PFPS Champions participated in the conference, and below they each share their experiences. The ISQua programme and presentations can be downloaded from their website www.isqua.org

Patients' input into ISQUA's Indicator Summit: Patient-Centered Indicators, measuring and acting on what is important for the patient

Garance Upham, PFPS Champion and Steering Group Member, France

Over 1100 delegates met in Paris from Oct 10-13 for the ISQUA conference to present ongoing work to make 'patient centred' health systems a reality.

Invited to attend a pre-conference satellite, the "Indicator Summit", Mrs Garance Upham, Member of the PFPS Steering Committee, focussed on issues surrounding patient-staff interactions which are often lost in 'patient satisfaction' assessments and 'patient indicators' in general.

Patients are most often considered as 'consumers' and not as actors - she said - this is not a difference in degree but an important difference in concept. Health systems managers are often reluctant to accept the patient as actor.

For example the French 'Haute Autorité de Santé' (HAS) has adopted and applied in the French hospital system the WHO Surgical Safety Checklist, to reduce common errors, but with 'slight' changes. In the original WHO Checklist it is written "site marked / not applicable", which means drawing with the patient or the family the site to be operated on (kidney, right leg, etc) whenever applicable. The HAS has omitted it. Yet that single measure is empowering patient and family to prevent 'wrong site' surgery, a common error according to OECD and WHO studies.

Garance's main point was that "monitoring staff attitude and behaviour towards patients" could be more telling than patient satisfaction questionnaires, and that life-threatening errors can often result from failure by staff to listen to patients as 'partners', and the tendency of some staff members to treat patients as less knowledgeable and inferior in some way.

Garance gave an example of a life-threatening medical error avoided at the last minute because the patient, a health professional herself, was able to bypass and even go against the medical advice of the health centre.

In French-speaking Africa, patient groups and health-care safety representatives have proposed and are developing a "STOP", ***Safe/Sterile Treatment Observed by the Patient***, itself adapted from an Indian community concept. ***Continued on page 5…***

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Garance proposed use of the ***BIAS FREE Framework*** (***B****est* ***I****ntegrative* ***A****nalytical* ***S****ystem for* ***R****ecognizing and* ***E****liminating inequities)* - http://www.biasfree.org/, a sociology framework which has proven successful in removing power bias in several instances (Costa Rica Women's Hospital, South Africa's Medical Research Council, etc.). The Bias Free Framework applies a triangle to evaluate biases: H - Hierarchy dominance of one group, F - Failure to examine differences, D - Double standards. Garance concluded: We don't want cosmetics, we want real meat! She listed a number of proposals, of which the holding of Bias Free Framework patient safety seminars was one.

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Garance suggested:
– Hospital Users Committees to be given access to all questionnaires filed by patients and study them and to be made public
– Users Committee/PFPS to partner with health care representative to set minimal patient safety standards
– Users Committee to engage in participatory implementation research on indicators
– Research on economic cost/benefit studies of patient engagement.

ISQua 2010

Margaret Murphy, PFPS Champion and Steering Group Member, Ireland

I write with an ever-increasing appreciation of the value of Patients for Patient Safety and I return from the ISQua Conference further energised.

If partnership has been defined as 'a relationship between individuals or groups that is characterized by mutual cooperation and responsibility, for the achievement of a specified goal, an alliance or association of persons for the prosecution of an undertaking', then the work of PFPS champions is testimony to the honest pursuit of partnership. Truth is that there is no conflict in relation to the goal, the undertaking, as perceived by health-care professionals and by patients. We are united in the desire for safe health care.

That is really well articulated in the report of the Irish Commission on Patient Safety and Quality Assurance which describes a Patient Safety Framework as **'Knowledgeable patients, receiving safe and effective care from skilled professionals in appropriate environments with assessed outcomes'.**

On Sunday 10 October, WHO held a meeting on the Multi Professional Patient Safety Curriculum Guide. We had a number of teleconferences prior to the meeting and had an opportunity to give feedback to the various iterations of the new documents.

Tribute was made to those who had worked on the undergraduate medical curriculum – PFPS Champions Mingming Zhang and Jorge Martinez had given significant input and it was good to see this continued through my own involvement with the new curriculum. It was also good to be able to identify portions of the curriculum which were clearly PFPS contributions.

On 11 October, Karen Luxford from Australia and I delivered a 90-minute session entitled 'The patient care experience – a key piece of the quality puzzle'. This was a lively interactive session during which I gave 3 short presentations - Strategies for Engaging Patients and Families at the Organizational Level; Why is Partnership Important?; Consumer Focus.

On the following day, I was involved in the session "Role of Governance and Leadership in Driving Quality Improvement." This was a discussion around three case studies which highlighted (1) the challenges of implementing the WHO Surgical Safety Checklist, (2) The challenges relating to the deteriorating patient (3) How do clinical leaders deal with poor clinical results. This was a real opportunity to bring the patients' perspective to these critical issues.

I feel strongly that our presence at large international conferences is very valuable – it affords a wonderful opportunity for further engagement. I will return to Paris in early December to give input to the Haute Autorité de Santé to share the Irish experience on patient involvement in hospital accreditation. Karen Luxford, Steph Newell and I might also collaborate on something for the 2011 ISQua meeting.

It is clear that our exposure to the wider audience benefits both the PFPS Champions and the health care community – many in Paris were astounded to learn of the variety of PFPS activities. To my fellow PFPS champions, I therefore say Congratulations!

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ISQua continued…

Jorge Martinez, PFPS Champion, Argentina

The ISQua Conference in Paris was an excellent opportunity to exchange ideas, concepts and assessments related to patient safety.

The message was that quality of care has to consider the patient at the center of the team. Patient satisfaction should be improved, permanently analyzing and understanding medical actions and patients' expectations.

I had the opportunity to participate in two WHO seminars; one related to the implementation of the Patient Safety Curriculum for Medical Schools, where I talked about my experience implementing the Curriculum at del Salvador University in Buenos Aires, Argentina. I mentioned that my main objective and commitment, was that students realize from the very beginning that although advances such as new drugs and technology help us to deliver more effective care, to reduce the risk of adverse events is the most important action for improving health and safety and that our main mission is to provide patients what they are expecting, need and deserve.

It was a very exciting experience. In the different paediatric settings, elements of patient safety were introduced: What is patient safety? What are human factors engineering? Minimizing infections, Improving medication safety,…

The strategy involved lectures, clinical placement at the bedside, on the ward activities. I also spoke about problems, potential solutions and proactive actions. The following lessons were learned: to join educators with the same passion and commitment, to not give up if you don't get immediate predisposition, and that this is the first step but if it's a solid one, things will improve.

In the other seminar, innovations and technical solutions were discussed to address patient safety problems. The importance and difficulties of implementing checklists were presented and discussed as well as the ICPS (International Classification of Patient Safety) framework to improve communication between health providers.

Sir Liam Donaldson, in the closing plenary, gave us the global vision regarding the past, present and future of WHO Patient Safety. He reinforced the main statement of "An Organization with a Memory". It was a superb experience presenting deep messages that should accompany attendees when returning home.

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Prevalence of Adverse Events in Peru

Nora Espiritu, PFPS Champion, Peru

I would like to comment on the "IBEAS" study conducted on adverse events (AE) in Latin America, in collaboration with WHO, the Pan-American Health Organization, the Ministry of Health and Social Policy in Spain, and the Ministries of Health and institutions in Argentina, Colombia, Costa Rica, Mexico and Peru, in which I participated during the first phase in my country, and the report was published this year.

In this study involving 58 hospitals in 5 countries of Latin America, a total of 11555 patients hospitalized for a week were assessed to find out if they suffered an AE. The overall prevalence of patients with any AE was 10.5% and 11.6% in Peru. The ICU and related services had the highest prevalence of AE (22.7%), but in my country the highest was obstetrics (24.9%) followed by intensive care units (21.4%).

The AE most frequently identified were associated with nosocomial infection or a procedure, while those related to medication were less prevalent. About 60% of nosocomial infections and 55% of procedure-related problems could have been avoided. A high percentage of AE prolonged hospitalization significantly (from 13.0 to 19.6 days on average) and the cost of care. 18.2% of AE caused a re-entry to hospital.

In Peru, the Ministry of Health is implementing a series of strategies to reduce adverse events and implementing complete packages for critical care and risk management teams to analyze and implement corrective measures. To include strengthening the functional organization, integrating the various professional groups, implementation of checklists in critical processes, hand hygiene and has initiated the project of zero infection in partnership with USAID and Johns Hopkins University.

To contact Nora for more information please email nora1652@yahoo.es

Next time…

If you have any news to share for the next newsletter please send contributions through to Anna, at leea@who.int before 7 January 2011.