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Patient Safety

A World Alliance for Safer Health Care
<http://www.who.int/patientsafety>

WHO-EU: Advancing Reporting & Learning Systems

Patient Safety & Quality of Care Working Group

4 November 2013

Centre Albert Borschette, Rue Froissart 36,
Brussels, Room AB 4C

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CONTENTS

- WHO Goal: building learning organizations
- WHO contribution
 - **WHO Draft Guidelines on Adverse Event Reporting and Learning Systems**
 - **From Draft Guidelines to ICPS**
 - **From ICPS to Minimal Information Model for Patient Safety**

WHO proposes to support the **European Commission** and its **Member States** to advance the development of a common **Minimal Information Model** for reporting patient safety incidents (**MIMPS**), aimed to **facilitate comparison, sharing and global learning** from the occurrence and actions around patient safety incidents



Towards building learning organizations



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Rationale for reporting in healthcare

When things go wrong in health care, it is essential to understand:

- – What happened?
 - – Why did it happen?
 - – What were the consequences?
 - – What can be done to mitigate the harm caused by it?
 - – And, what can be done to avoid this from happening again?
-
- However, there are no common standards for monitoring, reporting, classifying, analyzing and interpreting patient safety incident data

Core principles for
developing learning
organizations
through systematic
and organized data
collection

WORLD ALLIANCE FOR PATIENT SAFETY

WHO DRAFT GUIDELINES FOR ADVERSE EVENT REPORTING AND LEARNING SYSTEMS

FROM INFORMATION TO ACTION



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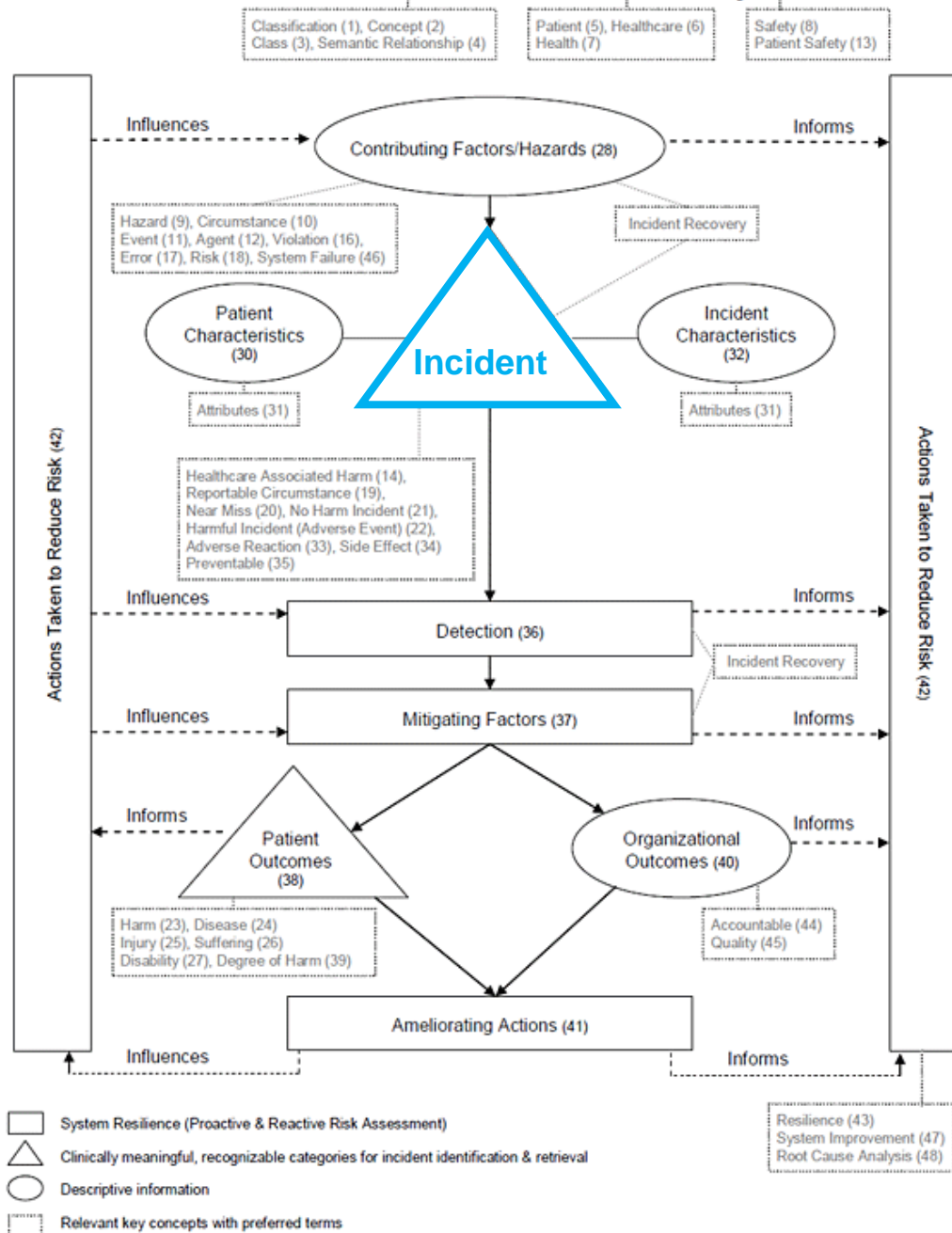
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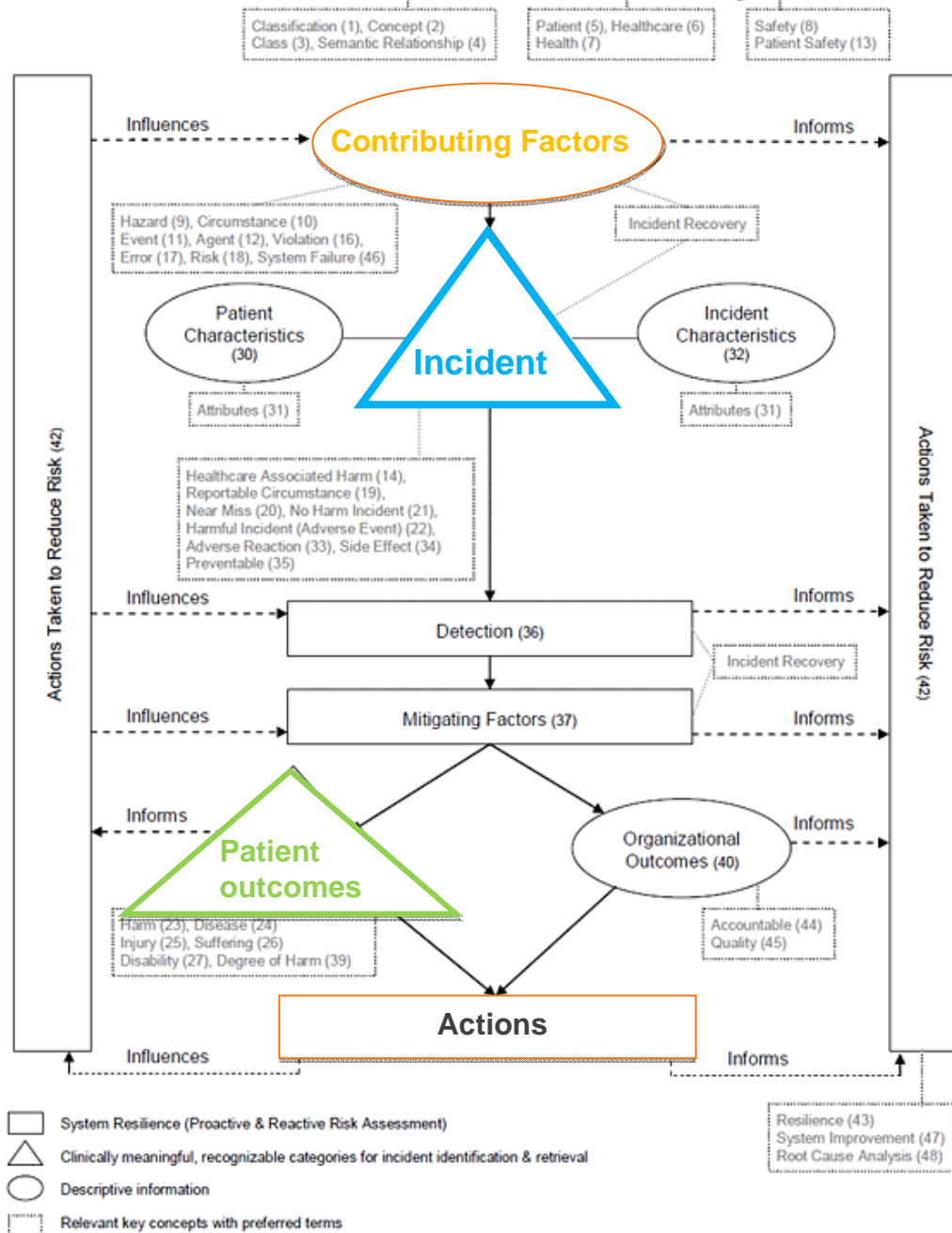
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Conceptual Framework for the International Classification for Patient Safety



A **patient safety incident** is an event or circumstance that could have resulted, or did result, in unnecessary harm to a patient.

Conceptual Framework for the International Classification for Patient Safety



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Next step: Minimal Information Model for Patient Safety

Goal:

- The minimal concepts & relationships from a report to elicit minimal learning & favor commonality across reporting systems

- Aiming to harmonize reporting
- And to be able to aggregate, compare and learn at institutional, national, international levels

The Minimal Information Model is the core common elements of any reporting system, which can later be expanded to suit the specific needs of any user.

MIM for Incident Reporting

- **Current draft MIM data categories are:**
 - Incident identification
 - » Patient
 - » Time
 - » Location
 - » Agent(s) involved
 - Incident type
 - Incident outcomes
 - Resulting actions
 - Reporter



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EC-WHO Grant Agreement

- In collaboration with the **EC_DG SANCO**, **WHO** will invite between **5 to 10 European institutions** from different EU countries
- to collaborate in **testing** and **adapting** a draft template developed by WHO and advising in modifications,
- and also to **explore** methods of **extracting a common learning dataset** from existing patientsafety reporting systems.

The project will be country driven

- WHO will invite national institutions to assess the **feasibility** of adapting the draft template and of building new reporting systems
- It will build on the experience of EUNET PASS and the DG SANCO Subgroup on Reporting & Learning to **map** existing practices of incident reporting across Europe highlighting gaps and challenges
- It will draw set of **preferred terms** for incident reporting.
- WHO will organize an expert consultation, involving European and world recognized experts to reach **consensus** in the expected outcomes.

Expected outcomes

- A **validated information template** (**Minimal Information Model for Patient Safety Reporting**) to facilitate harmonization of reporting systems, comparison and global learning
- **User's Guide** to facilitate use and training of the Information Model
- An assessment of the **feasibility** to adapt and build new reporting systems based on the Minimal Information Model for Patient Safety Reporting
- A set of **Preferred Terms** for the most frequent incident types with guidelines about its use
- **Scientific** and **advocacy** publications



January 2014

Kick-Off Meeting

- Project Presentation
- Initiation



February-August

Execution

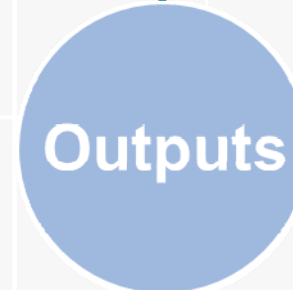
- Piloting
- Feasibility assessment
- Data gathering



Sept- Nov 2014



- ❖ DATA Analysis
- ❖ Review & Summary Documents
- ❖ Expert Consultation
- ❖ Consensus Building




**Intergovernmental Agencies,
National Agencies, Academia,
Experts**

**Recommendations for
structuring reporting
Systems through
MIMPS**

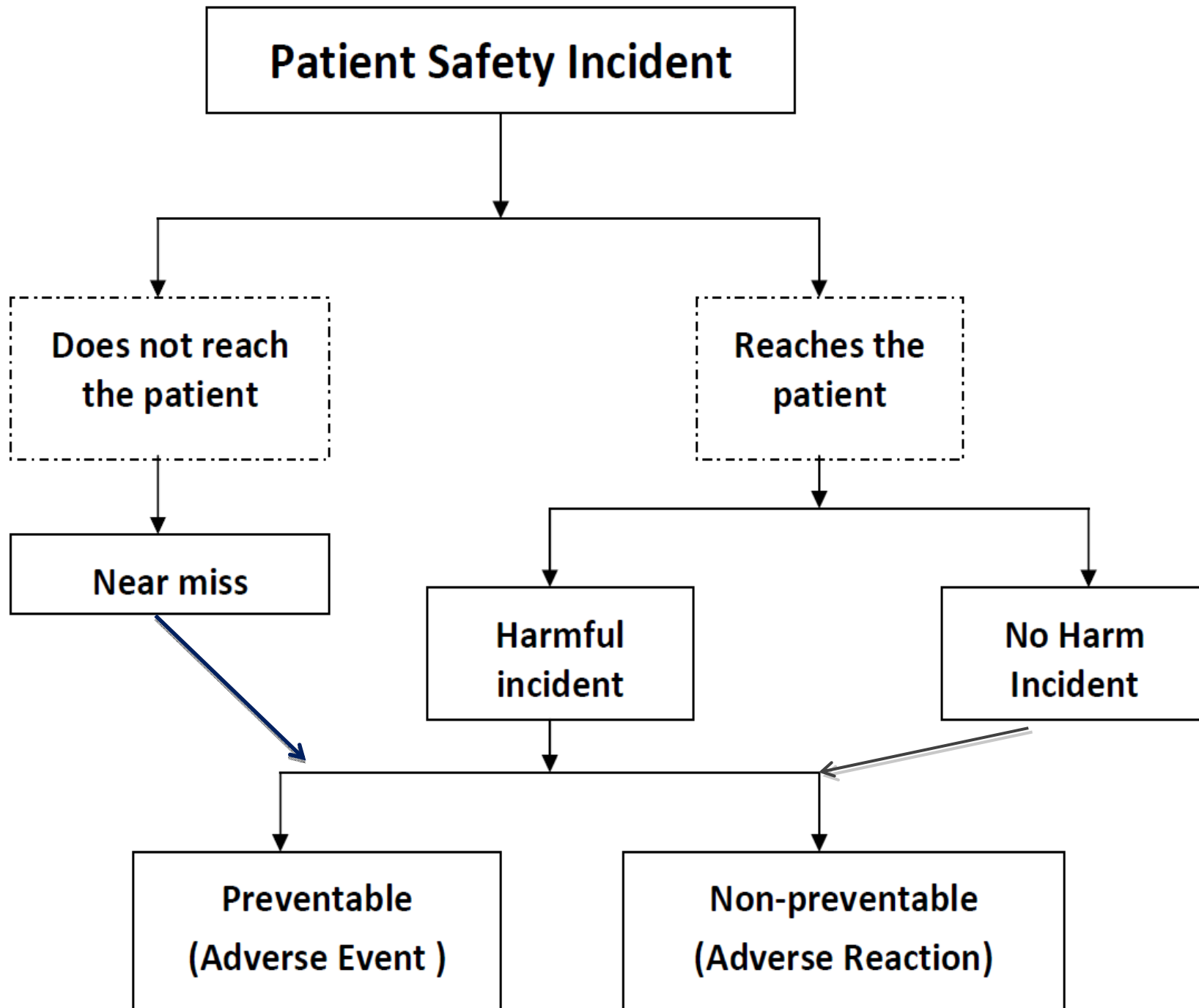
2014-2015

Challenges: more than data systems

- Need for complement with additional data sources
- Patient Safety culture: avoid blame and retaliation, promote learning and improvement
- Protective legal framework
- Develop learning systems

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- WHO invites the scientific community to join this effort and provide input to the development of the Minimal Information Model for Patient Safety Incident Reporting
 - Please, contact

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Thank you

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WHO
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