The WHO World Alliance for Patient Safety: towards the years of living less dangerously

Liam J Donaldson and Martin G Fletcher

ABSTRACT

- Improving the safety of patient care is now a global issue.
- In 2004, the World Health Assembly supported the creation of the World Alliance for Patient Safety to coordinate, spread and accelerate improvements in patient safety internationally.
- Australia has been at the forefront of international work on patient safety and is working closely with the World Alliance.
- The World Alliance is taking forward work in six main action areas: Patients for Patient Safety; Reporting and Learning; Taxonomy; Solutions; Research; and Global Patient Safety Challenge.
- Despite differences in context, there are many common challenges for countries seeking to establish patient safety programs and initiatives.
- Looking forward, long-term action on patient safety must be built and sustained with the commitment of policy makers and the active engagement of health care professionals.

MJA 2006; 184: S69–S72

In May 2004, the 57th World Health Assembly supported the creation of an international alliance to improve patient safety as a global initiative. The World Alliance for Patient Safety was launched in October 2004. The Alliance brings together a broad range of partners — ministries of health, safety experts, national agencies on patient safety, health care professional associations and consumers — to achieve improvements in patient safety worldwide. Here, we provide an overview of the major priorities of the Alliance and identify some of the main challenges facing the patient safety agenda internationally.

A body of research evidence stretching back 25 years points to unsafe care as a significant source of patient morbidity and mortality.[1-4] Publications such as *To err is human: building a safer health system* by the US Institute of Medicine and *An organisation with a memory* by the Chief Medical Officer in the United Kingdom have made patient safety much more visible on the policy agenda for many countries, accompanied by growing public debate on matters of health care safety.[5,6] Studies of adverse events have been published recently in New Zealand, Canada and Denmark,[7-9] and are under way in a number of other countries, including Spain and Brazil.

The creation of the World Alliance for Patient Safety underlines the fact that the safety of patient care is now recognised as a global issue. Even just 10 years ago, patient safety was not viewed as a core concern by most policy makers. Australia was one of the first countries to develop a comprehensive, national program of action on patient safety and has been at the forefront of international efforts. The Quality in Australian Health Care Study is widely regarded as seminal in its efforts to quantify and characterise patient safety problems on a large scale.[3] A number of those involved in patient safety initiatives in Australia have stepped up to play important leadership roles internationally. Specific safety initiatives are also highly regarded. This includes long established work on incident reporting through the Australian Patient Safety Foundation and the pioneering work of the Australian Council for Safety and Quality in Health Care in areas such as open disclosure.[10,11]

Differences between countries inevitably mean that approaches to patient safety must be adapted to ensure their local relevance. However, there are also many common challenges for countries seeking to establish patient safety programs and initiatives. All health systems coming to grips with patient safety must address:[12]

- how to prevent patients being harmed during health care;
- ways of quickly detecting patient harm and unsafe care;
- strategies to ameliorate the effects of any such harm on patients, their families and health care providers; and
- ways of ensuring system-wide learning which prevents harm to future patients from similar sources of risk.

Priorities of the World Alliance

The forward program for 2005 of the World Alliance for Patient Safety sets out an important and comprehensive international program within six main action areas:[12]

- Patients for Patient Safety;
- Reporting and Learning;
- Taxonomy for Patient Safety;
- Solutions for Patient Safety;
- Research for Patient Safety; and
- Global Patient Safety Challenge.

The wisdom of patients — patients for patient safety

Consumers of health care are at the heart of patient safety. When things go wrong, they and their families suffer from any harm caused.[12] Such harm is often made worse by the defensive and secretive way that many health care organisations respond in the aftermath of a serious event.

Around the world, health care organisations that are most successful in improving patient safety are those that encourage close cooperation with patients and their families.[13] Patients and their families have a unique perspective on their experience of health care and may provide information and insights that health care workers may not otherwise have known.[14]

The World Alliance is developing an international network of patients and patient organisations. This initiative, known as Patients for Patient Safety, will ensure that patient perspectives are an integral part of the international patient safety movement. A major strategy is to develop a cohort of patient champions drawn from different countries around the world (Box 1). Although Australia has a long tradition of consumer involvement in patient safety, in many other countries this is a new concept. A major challenge for Patients for Patient Safety is to identify the right starting point for action in varied cultural contexts across the world and in situations where a tradition of active patient involvement in health care provision may be much less established.

1 The power of partnership[15]

The world's first Patients for Patient Safety workshop was held in London, England, in November 2005.

Participants: The workshop brought together 24 patients and patient safety advocates whose experience established them as committed patient safety champions. Workshop participants were drawn from 20 different countries and were selected following a worldwide call reaching over 2000 organisations.

Achievements: The workshop endorsed a declaration calling for a greater role for patients to improve patient safety internationally. Action strategies were developed with a strong emphasis on working in partnership with health care authorities and providers.

Follow-up: Follow-up workshops are planned in all World Health Organization regions during 2006 and 2007. ◆

Learning from experience — the role of reporting

A central foundation for building well targeted safety initiatives is to better understand the nature of the safety problems that occur and the factors that contribute to them. Common sources of risk may otherwise go unnoticed if not reported and analysed.[6]

Adverse event reporting systems are emerging as a major area of interest for many countries.[12] The World Alliance has worked closely with Professor Lucian Leape of the Harvard School of Public Health to produce draft World Health Organization guidelines on adverse event reporting and learning systems to help countries develop or improve these systems.[16] These guidelines will be further refined with experience. Box 2 outlines important design principles for reporting systems derived from these draft guidelines.

While a growing interest in better methods of detecting patient safety problems is welcomed, the World Alliance recognises that reporting systems must be seen in their wider context. A particular need is to ensure that developments in systems of reporting are matched by developments in systems of response to what is reported.[16] For example, expert analysis of reported events and timely feedback of identified risks and hazards are required.

There is a continued need to address barriers to more open reporting by health care professionals. Fear of punishment, blame, lack of feedback and inadequate organisational support emerge as common challenges across many countries.

Finally, reporting on its own will never provide a complete picture of all that may have gone wrong and all that may be important to know. Multifaceted approaches to learning are needed, incorporating a variety of methods, such as clinical audit, pooled analysis of the findings of incident investigations, and proactive identification of risks.[16]

2 Characteristics of successful reporting and learning systems[16]

A successful reporting and learning system to enhance patient safety should ensure that:

- reporting is safe for the individuals who report
- reporting leads to a constructive response
- expertise and adequate resources are available to allow for meaningful analysis of reports
- the reporting system is capable of disseminating information on hazards and risks and recommendations for change. ◆

More than words — taxonomy for patient safety

Closely linked to developments in reporting systems is the potential for more systematic sharing of data and information about patient safety problems across countries. Currently, a wide range of definitions and terms are used to measure and report on patient safety problems.[17] For example, in the field of medication safety, a recent Australian study showed that more than 25 different terms were in use, with 119 associated definitions.[18] Such variation makes it almost impossible to usefully compare data within and across countries.

The World Alliance is working to develop an internationally acceptable framework for defining and classifying adverse events and near misses. The action area, Taxonomy for Patient Safety, seeks to define, harmonise and group patient safety concepts into a classification that will elicit, capture and analyse factors relevant to patient safety. The final product will be known as the International Patient Safety Event Classification. It is planned that this will be ready for field testing by early 2007.

Safety solutions

Safety solutions are interventions and actions which prevent recurrence of patient safety problems and reduce risks to patients. No patient safety knowledge is more important than how to prevent harm to patients. A wide range of solutions to safety problems are already in use in a number of countries (Box 3). As a first step, the World Alliance wants to ensure that these tried and tested solutions are made widely available.

The Alliance aims to increase international collaboration to spread existing solutions and better coordinate efforts to develop future solutions. This will require input from a range of stakeholders to identify priorities relevant to diverse country needs. To spearhead this program, WHO has designated the Joint Commission on Accreditation of Healthcare Organizations and Joint Commission International as a WHO Collaborating Centre on Patient Safety Solutions.

Timely implementation of risk-reduction strategies and safety interventions remains a major stumbling block for patient safety internationally. The same errors and system failures are often repeated. Action to reduce known risks is often too slow. This is illustrated by an audit of progress in implementing action on alerts on the safe administration of intrathecal (spinal) chemotherapy within the National Health Service in England.[22] Progress was slow despite the serious and high profile nature of the event to be prevented. The same audit showed worrying delays in implementation of other patient safety alerts.

Case studies such as this reveal much about the safety culture of health care. It is not yet clearly focused or organised enough to reduce potentially fatal risks to patients sufficiently rapidly. Diffusion of safer practice may follow the same trajectory as the adoption of good practice on the spread of innovation.[23] Consultation with countries and experts through the World Alliance suggests the challenge is not unique to any one country.

Knowledge is the enemy of unsafe care

Work on safety solutions is complemented by the action area Research for Patient Safety, which is initiating work to develop an agreed international research agenda for patient safety. This will address priorities for research in areas such as the effectiveness of safety interventions, research methodologies and the implementa-

3 Safety solutions from around the world

Incorrect administration of vincristine (intrathecal rather than intravenous)

The Joint Commission on Accreditation of Healthcare Organizations in the United States has produced a four-point checklist to follow when injecting drugs intrathecally to ensure that the right drug is injected in the right place.[19]

Incorrect placement of nasogastric feeding tubes

The National Patient Safety Agency (NPSA) in England and Wales has produced a Patient Safety Alert on correct and incorrect testing methods.[20]

The NPSA is collaborating with the UK Medicines and Healthcare products Regulatory Agency, as well as industry, to identify possible improvements to feeding tube design.

Wrong-site surgery

The Joint Commission on Accreditation of Healthcare Organizations has produced a Universal Protocol which outlines steps for ensuring right patient, right procedure, right site.[21] This has been adapted for use by the Australian Council for Safety and Quality in Health Care, as well as the Danish Patient Safety Society. ◆

tion of changes in safety practices. The World Alliance is also commissioning a multi-country research project to better understand sources of patient harm in a cross-section of developing and transitional countries, where far less is known about the nature of patient safety problems.

Global Patient Safety Challenge

A flagship initiative of the World Alliance is the formulation of a Global Patient Safety Challenge over a 2-year cycle of action. The purpose of the Challenge is to galvanise global commitment and action on a specific patient safety topic which addresses a significant area of risk relevant to all WHO member states.[12]

The topic chosen for the first Global Challenge is health care-associated infection, focusing over 2005–2006 on the theme *Clean care is safer care*.[24] Health care-associated infection is a growing threat to the safety of patient care. At any given time, more than 1.4 million people worldwide are estimated to have an infection acquired in a health care facility.[24]

The *Clean care is safer care* Challenge was launched internationally in October 2005. Australia, along with nine other countries, actively participated in the launch. The Challenge brings together the expertise of leading specialists in infection prevention and patient safety to catalyse worldwide commitment by policy makers, health care workers and patients to make *Clean care is safer care* an everyday reality in all WHO member states.

A key action within the Global Challenge is to promote hand hygiene in health care. Poor hand hygiene among health care providers is a worldwide problem. To provide the best scientific evidence and recommendations to health care workers, hospital managers and health authorities to improve practices, WHO has developed new *Guidelines on hand hygiene in health care (advanced draft)*.[25]

Strategy that counts

The World Alliance for Patient Safety is an important vehicle for collaborative action on patient safety across the world. However, growing interest in the safety of patients among policy makers and clinical leaders must also be matched by action.

There is a continued need to build and maintain strong political will and commitment to comprehensive and sustained action. As exemplified by other high-risk industries, such as aviation, commitment is needed over the long term.

Engagement of front-line health care workers is also vital in building a more open safety culture. A key factor is the need to balance individual and organisational responsibilities for patient safety. Patient safety requires well designed processes and structures of health care delivery. Competent, conscientious and risk aware health care providers are also essential at the "sharp end".

Australia has played a vital role in helping to establish an international agenda for patient safety. The World Alliance for Patient Safety looks to Australia to continue to play a leadership role in meeting the future challenges of the patient safety agenda internationally. Australian health care leaders and consumers are now needed in the global movement for patient safety to ensure the years ahead are years of living less dangerously.

Acknowledgements

This article is published with permission of the World Health Orginization, which holds copyright, with all rights reserved (2006).

Competing interests

None identified.

Author details

Sir Liam J Donaldson, MD, FFPHM, FRCP, Chair[1]
Martin G Fletcher, BSocStud, BA(Hons), MMan, Technical Advisor[2]
1 World Alliance for Patient Safety, Geneva, Switzerland.
2 World Health Organization, Geneva, Switzerland.
Correspondence: fletcherm@who.int

References

1 Brennan TA, Leape LL, Laird N, et al. Incidence of adverse events and negligence in hospitalised patients: results of the Harvard Medical Practice Study. *N Engl J Med* 1991; 324: 370-377.
2 Leape LL, Brennan TA, Laird N, et al. The nature of adverse events in hospitalized patients. Results of the Harvard Medical Practice Study II. *N Engl J Med* 1991; 324: 377-384.
3 Wilson RM, Runciman WB, Gibberd RW, et al. The Quality in Australian Health Care Study. *Med J Aust* 1995; 163: 458-471.
4 Vincent C, Neale G, Woloshynowych M. Adverse events in British hospitals: preliminary retrospective record review. *BMJ* 2001; 322: 517-519.
5 Institute of Medicine. Kohn LT, Corrigan JM, Donaldson MS, editors. To err is human. Building a safer health system. Washington DC: National Academies Press, 1999.
6 Department of Health. An organisation with a memory: report of an expert group on learning from adverse events in the NHS chaired by the Chief Medical Officer. London: HMSO, 2000.
7 Davis P, Lay-Yee R, Briant R, et al. Adverse events in New Zealand public hospitals I: occurrence and impact. *N Z Med J* 2002; 115: U271.
8 Baker GR, Norton PG, Flintoft V, et al. The Canadian Adverse Events Study: the incidence of adverse events among hospital patients in Canada. *CMAJ* 2004; 170: 1678-1686.
9 Schioler T, Lipczak H, Pedersen BL, et al; Danish Adverse Event Study. [Incidence of adverse events in hospitals. A retrospective study of medical records] [Danish]. *Ugeskr Laeger* 2001; 163: 5370-5378.
10 Runciman W. Lessons from the Australian Patient Safety Foundation: setting up a national patient safety surveillance system — is this the right model? *Qual Saf Health Care* 2002; 11: 246-251.
11 Australian Council for Safety and Quality in Health Care. What is open disclosure? Canberra: ACSQHC, 2004. Available at: http://www.safetyandquality.org/index.cfm?page=Action#opendisc (accessed Mar 2006).

12 World Alliance for Patient Safety forward programme 2005. Geneva: World Health Organization, 2004. Available at: http://www.who.int/patientsafety/information_centre/en/ (accessed Mar 2006).
13 Walshe K, Boaden R. Introduction. In: Walshe K, Boaden R, editors. Patient safety research into practice. Maidenhead, UK: Open University Press, 2006.
14 Giles S, Fletcher M, Baker M, et al. Incident reporting and analysis. In: Walshe K, Boaden R, editors. Patient safety research into practice. Maidenhead, UK: Open University Press, 2006.
15 World Alliance for Patient Safety. A year of living less dangerously. Geneva: World Health Organization, 2005. Available at: http://www.who.int/patientsafety/information_centre/en/ (accessed Mar 2006).
16 World Alliance for Patient Safety. WHO draft guidelines on adverse event reporting and learning systems. Geneva: World Health Organization, 2005. Available at: http://www.who.int/patientsafety (accessed Mar 2006).
17 Loeb J, Chang A, World Health Organization. Patient safety: reduction of adverse events through common understanding and common reporting tools. Towards an International Patient Safety Taxonomy: a review of the literature on existing classification schemes for adverse events and near misses; a draft framework to analyze patient safety classifications. Geneva: WHO, 2003. Available at: http://www.who.int/patientsafety/taxonomy/JCAHOReport12-30June03.pdf (accessed Mar 2006).
18 Yu KH, Nation RL, Dooley MJ. Multiplicity of medication safety terms, definitions and functional meanings: when is enough enough? *Qual Saf Health Care* 2005; 14: 358-363.
19 Joint Commission on Accreditation of Healthcare Organizations. Preventing vincristine administration errors. Sentinel event alert. Issue 34 — 14 Jul 2005. Available at: http://www.jointcommission.org/SentinelEvents/ (accessed Mar 2006).
20 National Patient Safety Agency. Reducing the harm caused by misplaced naso and orogastric feeding tubes in babies under the care of neonatal units. Alert issued 18 Aug 2005. Available at: http://www.npsa.nhs.uk/site/media/documents/1296_PatientSafetyAlert.pdf (accessed Mar 2006).
21 Joint Commission on Accreditation of Healthcare Organizations. A follow-up review of wrong site surgery. 5 Dec 2001. Available at: http://www.jointcommission.org/SentinelEvents/SentinelEventAlert/sea_24.htm (accessed Mar 2006).
22 Department of Health. Annual report of the Chief Medical Officer, 2004. London: HMSO, 2005.
23 Plesk P. Spreading good ideas for better health care. A practical toolkit. Dallas, Tex: VHA Inc, 2000.
24 World Alliance for Patient Safety. Global Patient Safety Challenge 2005–2006. Clean care is safer care. Geneva: World Health Organization, 2005.
25 World Alliance for Patient Safety. WHO guidelines on hand hygiene in health care (advanced draft): a summary. Geneva: World Health Organization, 2005.

(Received 15 Jan 2006, accepted 5 Apr 2006) ❑