Policy Brief

Safer hospitals for safer patient care

What is patient safety?

Safety is a fundamental principle of patient care and a critical component of quality management. It is defined as freedom from accidental error (*1*). Safety of patients is a critical dimension of quality and should be considered within the context of health care delivery and health systems. Patient safety is "a discipline in the health care sector that applies safety science methods toward the goal of achieving a trustworthy system of health care delivery. Patient safety is also an attribute of health care systems; it minimizes the incidence and impact of, and maximizes recovery from, adverse events."(*2*)

How serious is the problem?

In 1999, a seminal report from the Institute of Medicine in the United States (*1*), estimated that in the United States of America 44 000 to 98 000 people each year died from medical errors and that medical errors were the eighth leading cause of death in the United States. Information regarding the rate of adverse events experienced as a result of health care delivery in developing countries, remains glaringly underreported and poorly documented. While validated tools for measurement are available, putting such tools into practice and improving their efficiency is of utmost importance, particularly where medical resources are inadequate.

Globally, it is estimated that an average of 10% of all hospital admissions result in some form of unintended harm (*3*). A study conducted in the Region, during the period between 2006 and 2008, demonstrates that up to 18% of inpatient admissions in selected hospitals in some countries are associated with adverse events and 2.8% of all admissions were associated with death or permanent disability (Box 1). Up to 83% of these adverse events were judged to be preventable (*4*).

Why do breaches in patient safety occur?

The above-mentioned study provides compelling evidence that one of the main contributory factors associated with the occurrence of adverse events is the lack of policies and standard operating procedures that ensure appropriate health care delivery. Another contributory factor is that care is delivered under pressure, in a complex environment. In resource-poor settings, this is further compounded by the lack of trained staff. Lack of policies, procedures and a culture of safety rank high among priority areas

BOX 1 | Definitions and patient safety in the Eastern Mediterranean Region

Definitions
- Near miss: an event or situation that did not produce patient injury, but only because of chance
- Adverse event: any injury, complication or death resulting from processes of health care, not the underlying condition (*5*)
- Sentinel event: an unexpected adverse event in which death or serious harm to a patient has occurred

Patient safety in the Region
- Up to 18% of inpatient admissions in selected hospitals were associated with adverse events
- Up to 83% of these adverse events were judged to be preventable
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for improving patient safety and have massive implications for health care delivery and health systems in developing countries.

Human error is only part of the problem of lapses in patient safety. Studies have shown that adverse events are commonly associated with failures and/or defects in medical system design, organization, operation and management (*1*). The argument that errors could be reduced by redesigning systems and processes using human factors principles is persuasive (*2*).

One of the major challenges to patient safety is the avoidance of a culture of blame and the gradual establishment of a conducive environment in the health care system built on transparency and willingness to change (Box 2). Establishing mutual trust between patients and health care providers is another key strategy in promoting patient safety.

BOX 2 | A systems approach to patient safety

The person approach focuses on the errors of individuals, blaming them for forgetfulness, inattention or moral weakness

The systems approach concentrates on the conditions under which individuals work and tries to build defences to avert errors or mitigate their effects (*6*)

World Health Organization

Regional Office for the Eastern Mediterranean

What can ministries of health do to address patient safety?

The following are actions that ministries of health and professional associations can take to improve patient safety at national level.

- Recognize patient safety as an important public health problem requiring urgent action.
- Disseminate targeted messages and advocate for patient safety to a wide range of audiences, including health care decision-makers, managers, providers and the general public.
- Establish a national patient safety committee.
- Conduct continuous assessment of the prevalence of adverse events throughout the country.
- Develop a strategic plan for improving patient safety based on the results of assessment.
- Introduce patient safety in the medical and other health-related curricula (nurses, midwives etc).
- Develop, implement and monitor the use of management protocols and standard operating procedures.
- Implement a national unified medical records system.
- Endorse the national infection control programme.
- Require hospitals to develop evidence-based clinical and treatment guidelines, particularly in the fields of surgery (general and specialty), obstetrics and internal medicine.
- Commission the evaluation of health care facilities against multidisciplinary organizational standards and make resources available to address priority areas that have an impact on health care outcomes.

How can WHO help?

The WHO patient safety programme was launched in October 2004 in response to a World Health Assembly resolution in 2002 urging WHO and Member States to pay the closest possible attention to patient safety. This worldwide endeavour brought together the heads of agencies, health policy-makers, WHO and patient groups to advance the fundamental goal of "First, do no harm" and to reduce the potential for causing unwarranted harm to patients. The fundamental purpose of the WHO patient safety programme is to facilitate the development of a patient safety policy through the fulfilment of a number of core functions and other short-term initiatives. WHO and its regional offices provide technical support and capacity-building to ministries of health and affiliated institutions to assist countries in initiating and sustaining patient safety programmes.

What action areas is WHO involved in?

A comprehensive package of interventions and initiatives is provided by WHO:

- guidelines on hand hygiene in health care (7);
- safe surgery checklist (8): the main tool of the second Global Patient Safety Challenge: Safe Surgery Saves Lives;
- Patients for Patient Safety: an initiative designed to ensure that the perspective of patients and their families is a central reference point in shaping the focus of the work of the patient safety programme;
- guidance papers on the interactions between technology and patient safety.

WHO places emphasis on education and training. It is developing an international classification for patient safety, a global community of practice for reporting and learning systems for medical errors and "near misses" and a patient safety curriculum guide for medical schools.

What action is being taken at regional level

WHO Regional Office for the Eastern Mediterranean has adopted a regional strategy with five main axes to address patient safety (Figure 1). In 2006, the Regional Office launched an initiative called the Patient Safety Friendly Hospital Initiative. The initiative aims primarily at improving the level of patient safety in health care facilities by encouraging them to meet a comprehensive set of patient safety standards. A manual comprising the standards and tools for assessment of hospitals has been developed. Patient safety standards (see Box 3) are a set of requirements that are essential for the establishment of a patient safety programme at hospital level. Following assessment, institutions are provided with technical assistance to improve the level of patient safety in those domains that are found to be weak. Particular attention is given to the 20 critical standards which are absolutely essential for any hospital to be considered at the basic level of patient safety. The patient safety friendly hospital initiative complements efforts towards accreditation of hospitals and aims to improve health care quality.

What are the steps for hospitals to implement the initiative?

1. All hospitals are welcome to participate, whether public or private. Hospitals can express their interest in undertaking the initiative by contacting the patient safety focal point at the Ministry of Health or the Health Care Delivery Programme, WHO Regional Office for the Eastern Mediterranean in the interim.
2. The hospital receives the patient safety standards and indicator documents that will be used for the evaluation before the assessment visit. The hospital management team prepares the documents required for the assessment.
3. Assessment is performed by a team of regional experts over a 2–3 day period and an action plan is developed and provided to the hospital along with a package of interventions, based on priority areas identified for improvement.
4. A follow up assessment is performed after 6–9 months
5. Expansion at national level is encouraged with the Ministry of Health nominating a group of hospitals for training and baseline assessment.

At present there is a limited number of regional experts who have the experience to undertake this assessment. The Regional Office is making concerted efforts to expand the number of trained
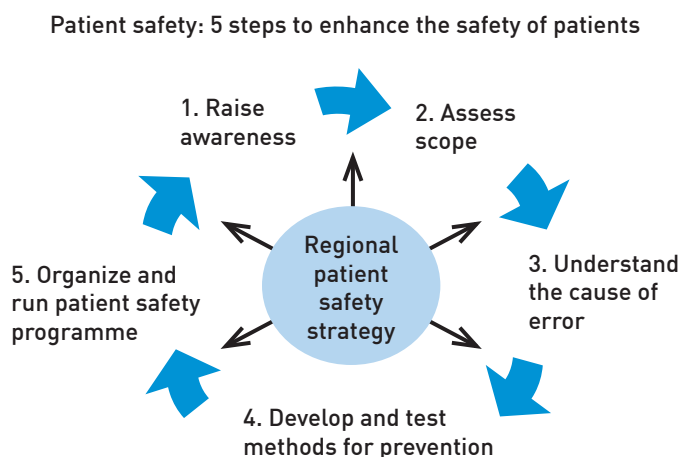
Patient safety: 5 steps to enhance the safety of patients

Figure 1. Eastern Mediterranean Region patient safety

References

1) Institute of Medicine. *To err is human: building a safer health system*. Washington, D.C., National Academy Press, 1999.

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3) *10 facts on patient safety*. Geneva, World Health Organization. Available at: http://www.who.int/features/factfiles/patient_safety/en/index.html

4) Wilson RM et al. WHO EMRO-AFRO Adverse event prevalence study report. The Northern Centre for Healthcare Improvement, Sydney, Australia.

5) Rosenthal J, Riley T. *Patient Safety and medical Errors: a roadmap for state action*. National Academy for State Health Policy. 2001.

6) Reason J. Human error: models and management. *BMJ*, 2000, 320:768-770.

7) *Guidelines on hand hygiene in health care*. Geneva, World Health Organization, 2009. Available at: http://whqlibdoc.who.int/hq/2009/WHO_IER_PSP_2009.07_eng.pdf

8) Haynes AB et al. Safe Surgery Saves Lives Study Group. A surgical safety checklist to reduce morbidity and mortality in a global population. *The New England Journal of Medicine,* 2009, 360:491–499.

BOX 3 | **Patient safety friendly hospitals initiative assessment manual**

140 standards for patient safety in hospitals are included in the assessment manual and are divided across the following domains:
A. Leadership and management
B. Patient and public involvement standards
C. Safe evidence-based clinical practices
D. Safe environment
E. Lifelong learning

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assessors and to encourage ownership of the initiative by ministries of health or other recognized agencies in countries. Once this stage is reached, assessment of hospitals will be undertaken by national experts and the Regional Office will continue to provide technical support as and when required. Currently, hospitals are being selected based on criteria developed by the respective ministries of health, in collaboration with WHO country offices. For more information, please contact: hcd@emro.who.int

What are the benefits of implementing patient safety programmes?

Implementation of a comprehensive patient safety programme is likely to:
• reduce adverse events
• reduce death and disability caused by health care delivery
• reduce health care costs
• strengthen credibility and promote trust between patients and providers
• build confidence in the health services and improve the image of health facilities.

What can hospitals do to improve the safety of patients?

Hospitals can take immediate steps to ensure patient safety. Among the key steps are the following.
• Identify leadership, whether this is represented by a person, a committee, or an institution.
• Build the will to change and create a common vision to eliminate preventable harm.
• Put in place an appropriate management system and identify the requisite improvement and implementation tools.
• Consider cultural aspects to ensure that improvement strategies are effective.

For more information, please contact: World Health Organization, Regional Office for the Eastern Mediterranean www.emro.who.int, email: hcd@emro.who.int