III International Conference on Patient Safety -- Patients for Patient Safety

Patient Safety Solutions

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World Alliance on Patient Safety Strands

- Global Patient Safety Challenge
- Patients for Patient Safety
- International Patient Safety Events Taxonomy
- Reporting Systems
- Research
- Dissemination of Patient Safety Solutions

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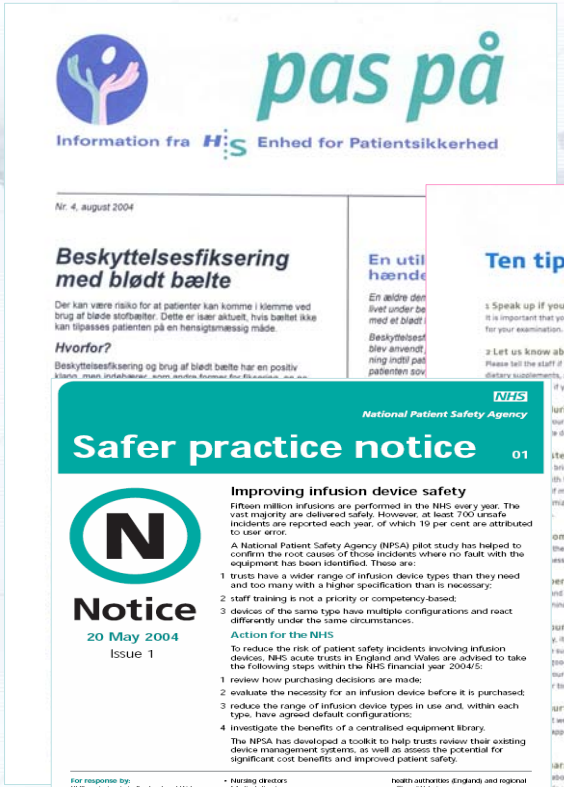
Solutions for Patient Safety



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Definition

A Patient Safety Solution is any system design or intervention that has demonstrated the ability to prevent or mitigate patient harm stemming from the processes of health care.

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WHO Collaborating Center on Patient Safety Solutions

- Identify Current Regional Safety Problems and Solutions Available
- Understand Regional Barriers to Solutions
- Assess Risk of Solutions
- Adapt Solutions to Local/Regional Needs
- Develop Disseminate Solutions

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Solutions Development Process

- Literature Search – March-April 2007
- International Steering Committee - April
- Complete Draft Solutions – Apr-Aug
- Review by Advisory Groups – Aug-Nov
- International Field Review – Dec-Feb
- Approval by International Steering Committee - April 2008

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International Collaborative Network

- Advisory Structure & Network
  - International Steering Committee
  - Regional Advisory Councils
  - National Patient Safety Agencies
  - National Accrediting Bodies
  - NGOs & Others (IHF, WMA, NPSF, etc.)

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Utilize Global Regional Advisory Councils

Assure appropriateness of solutions to unique health care systems in countries

- Asia-Pacific
- Middle East and Northern Africa
- Europe
- Africa
- Americas

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2007 Solutions – inaugural set

- **Look-Alike, Sound-Alike Medication Names**
- **Patient Identification**
- **Communication During Patient Hand-Overs**
- **Performance of Correct Procedure at Correct Body Site**
- **Control of Concentrated Electrolyte Solutions**
- **Assuring Medication Accuracy at Transitions in Care**
- **Avoiding Catheter and Tubing Mis-connections**
- **Single Use of Injection Devices**
- **Improved Hand Hygiene to Prevent Health Care Associated Infections**

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Template for Solutions

- Statement of Problem and Impact
- Associated Issues
- Suggested Actions
- Looking Forward
- Strength of Evidence
- Applicability
- Engaging Patients and Families
- Potential Barriers
- Risks for <unintended Consequences
- Selected References adn Resources

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Aide Memoire

Communication During Patient Hand-Overs

Patient Safety Solutions
| volume 1, solution 3 | May 2007

Gaps in hand-over (or hand-off) communication between patient care units, and between and among care teams, can cause serious breakdowns in the continuity of care, inappropriate treatment, and potential harm for the patient. The recommendations for improving patient hand-overs include using protocols for communicating critical information; providing opportunities for practitioners to ask and resolve questions during the hand-over; and involving patients and families in the hand-over process.

Engaging Patients and Families

- Provide information to patients about their medical conditions and treatment care plan in a way that is understandable to the patient.
- Make patients aware of their prescribed medications, doses, and required time between medications.
- Inform patients who the responsible provider of care is during each shift and who to contact if they have a concern about the safety or quality of care.
- Provide patients with the opportunity to read their own medical record as a patient safety strategy.

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Engaging Patients and Families

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- Create opportunities for patients and family members to address any medical care questions or concerns with their health care providers.
- Inform patients and family members of the next steps in their care, so they can be available to communicate this to the care provider on the next shift, and so they are prepared to be transferred from one setting to the next, or to their home.
- Involve patients and family members in decisions about their care at the level of involvement that they choose.

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2008 Solutions

1. Preventing Pressure Ulcers
2. Responding to the Deteriorating Patient
3. Communicating Critical Test Results
4. Preventing Central Line Infections
5. Preventing Patient Falls in Health Care Organizations

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Action on Patient Safety – High 5s

- To achieve significant, sustained, and measurable reduction in the occurrence of 5 patient safety problems over 5 years in at least 7 countries and
- To build an international, collaborative learning network that fosters the sharing of knowledge and experience in implementing innovative, standardized, safety operating protocols.

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High 5s Solution Topics

- Communication During Patient Hand-overs
- Performance of Correct Procedure at Correct Body Site
- Medication Reconciliation
- Control of Concentrated Electrolyte Solutions
- Hand Hygiene

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High 5s Participating Countries

- Australia
- Canada
- Germany
- Netherlands
- New Zealand
- United Kingdom
- United States

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Phases of High 5s Initiative

- Phase One – Launch and Development of Standardized Protocols
- Phase Two – Learning
- Phase Three – Evaluation and Spread

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National Patient Safety Goals

- Annual selection of topics
- Patient Safety experts prioritize topics
- National Field Review of draft NPSGs
- Requirement of Accreditation

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2008 National Patient Safety Goals

1. Patient identification
2. Communication among caregivers
3. Medication safety
7. Health care-associated infections
8. Medication reconciliation
9. Patient falls
10. Flu & pneumonia immunization
11. Surgical fires
13. Patient involvement
14. Pressure ulcers
15. Focused risk assessment (suicide; home fires)
16. Rapid response to changes in patient condition

➔ Universal Protocol for Preventing WSS

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NPSG #13

Goal 13: Encourage the active involvement of patient and their families in the patients own care as a patient safety strategy

Requirement: Define and communicate the means for patients and their families to report concerns about safety and encourage them to do so.

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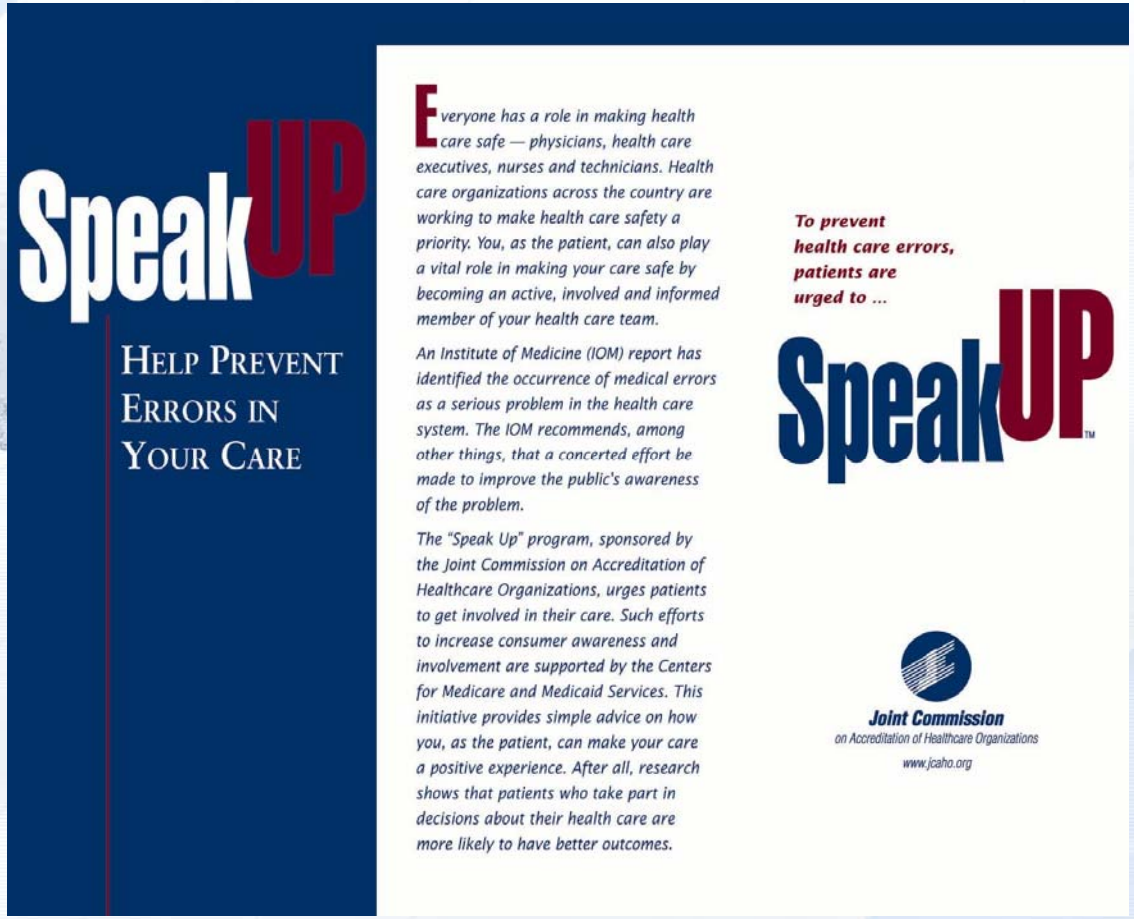

Organizations can order campaign buttons that can be worn by staff.

Brochures can be printed that have a blank panel to allow for information about the organization, its commitment to patient safety, and the organization logo.

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Speak Up

To help prevent health care errors, patients are urged to:

Speak up if you have questions or concerns, and if you don't understand, ask again. It's your body and you have a right to know.

Pay attention to the care you are receiving. Make sure you're getting the right treatments and medications by the right health care professionals. Don't assume anything.

Educate yourself about your diagnosis, the medical tests you are undergoing, and your treatment plan.

Ask a trusted family member or friend to be your advocate.

Know what medications you take and why you take them. Medication errors are the most common health care mistakes.

Use a hospital, clinic, surgery center, or other type of health care organization that has undergone a rigorous on-site evaluation against established, state-of-the-art quality and safety standards, such as that provided by the Joint Commission.

Participate in all decisions about your treatment. You are the center of the health care team.

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For more information:

The Joint Commission International Web Site
www.jcrinc.com
The Joint Commission Web Site
www.jointcommission.org
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