The WHO World Alliance for Patient Safety

World Health Organization

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The WHO World Alliance:

- Launched in October 2004
- WHO Secretariat
- Chair Sir Liam Donaldson, CMO England & Wales
- Collaborative Model

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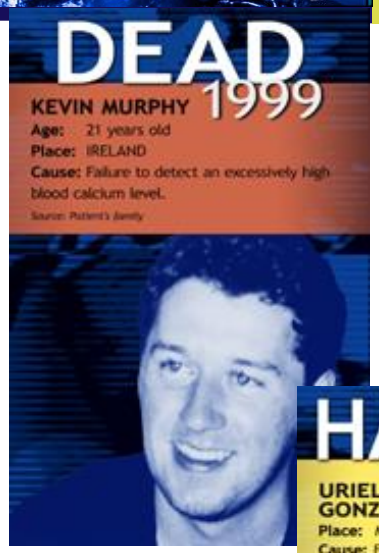
Patients first



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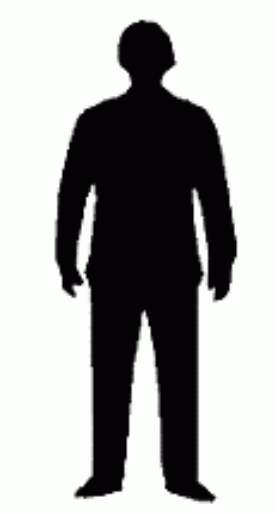
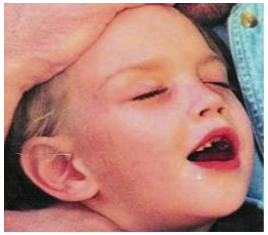
Opportunities for risks are ubiquitous



CLINICIAN → TEAM → HOSPITAL → HEALTH SYSTEM → POTENTIAL FOR HARM



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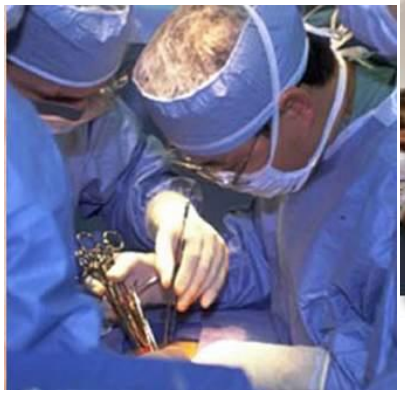
Safety Culture

- Acknowledgement
- Patients & Professionals first
- Learning
- Improvement
- Leadership & Individual commitment
- Collaboration & team work



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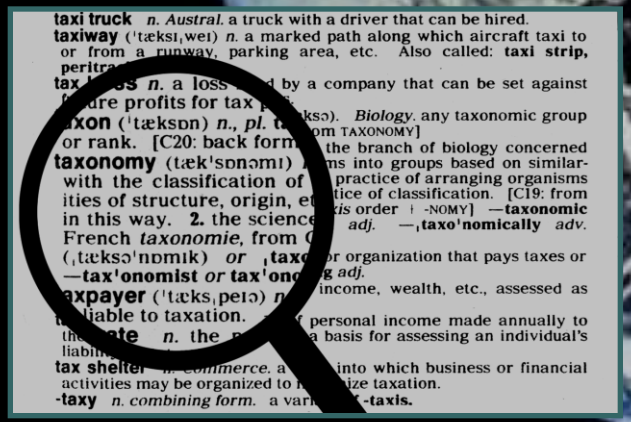

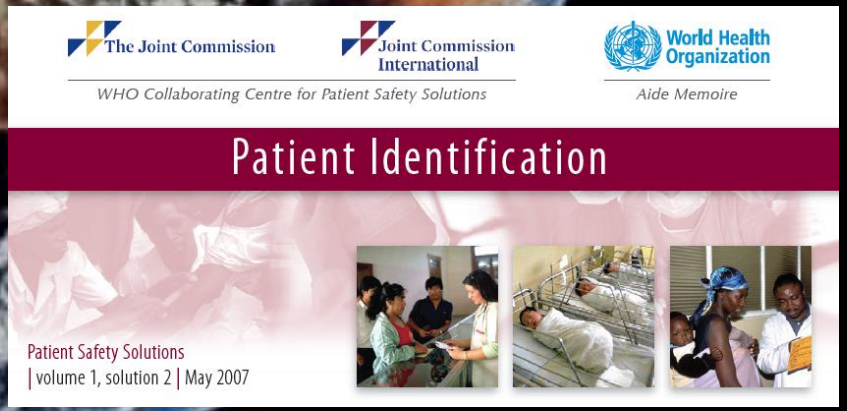

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Goals

Clean Care is Safer Care

- Increase awareness about health care associated infections
- Increased compliance with WHO Hand Hygiene guidelines
- Reduce hospital Care infections

In Progress

- Pilot testing (8 sites) implementation strategy
- Network of Complementary sites

More than 75% world population in countries committed to control Health Care Associated Infections

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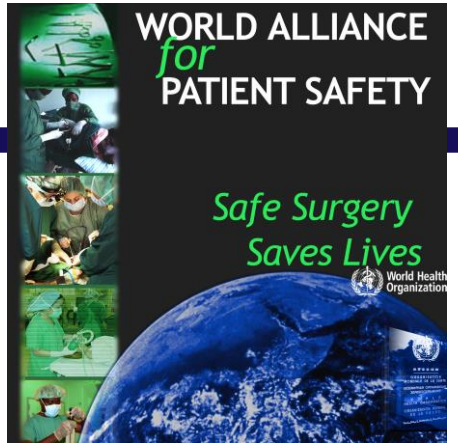
81 countries committed to reduce HCAI

Safe Surgery Saves Lives



- Make safe surgery a public health issue
- Reduce surgical injuries and deaths
- Widespread use of surgical safety checklist

SURGICAL SAFETY CHECKLIST

(DRAFT)

SAFER SURGERY SAVES LIVES
GLOBAL PATIENT SAFETY CHALLENGE
WORLD HEALTH ORGANIZATION

SIGN IN - PRIOR TO INDUCTION OF ANAESTHESIA, THE FOLLOWING ITEMS MUST BE COMPLETED:

- □ CONSENT OBTAINED
- □ SITE MARKING DONE/NOT APPLICABLE
- □ PATIENT CONFIRMED IDENTITY, SITE AND PROCEDURE
- □ ANAESTHESIA SAFETY CHECK COMPLETED

DOES PATIENT HAVE A:

KNOWN ALLERGY	□ NO	□ YES
RISK OF >1000CC BLOOD LOSS	□ NO	□ YES, AND ADEQUATE IV ACCESS ESTABLISHED
DIFFICULT AIRWAY (E.G. MALLAMPATI 3 OR 4)	□ NO	□ YES, AND ASSISTANCE AVAILABLE

TIME OUT - PRIOR TO SKIN INCISION, THE FOLLOWING ITEMS MUST BE COMPLETED:

- □ SURGEON, NURSE, AND ANAESTHESIA PROFESSIONAL VERBALLY CONFIRM PATIENT, SITE, PROCEDURE, POSI
- □ ANTIBIOTIC PROPHYLAXIS GIVEN IN LAST 60 MIN — □ NOT APPLICABLE
- □ DVT PROPHYLAXIS (HEPARIN, BOOTS/STOCKINGS, OTHER) — □ NOT APPLICABLE
- □ ESSENTIAL IMAGING DISPLAYED — □ NOT APPLICABLE

ANTICIPATED CRITICAL EVENTS

- □ SURGEON REVIEWS: WHAT ARE THE CRITICAL OR UNEXPECTED STEPS, OPERATIVE DURATION, ANTICIPA
- □ ANAESTHESIA TEAM REVIEWS: WHAT IS THE RESUSCITATION PLAN, PATIENT-SPECIFIC CONCERNS?
- □ NURSING TEAM REVIEWS: WHAT ARE THE STERILITY INDICATOR RESULTS, EQUIPMENT ISSUES, OTHER PA

□ OTHER CHECKS: _____

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Patients empowerment & networking for patient safety

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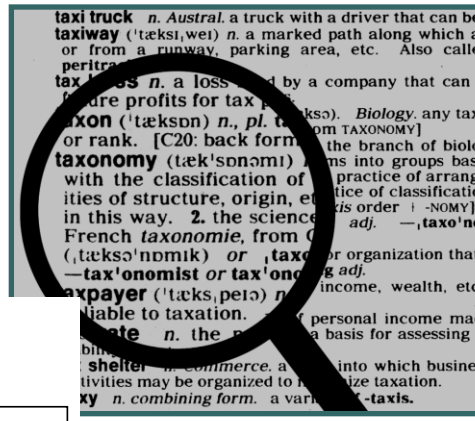
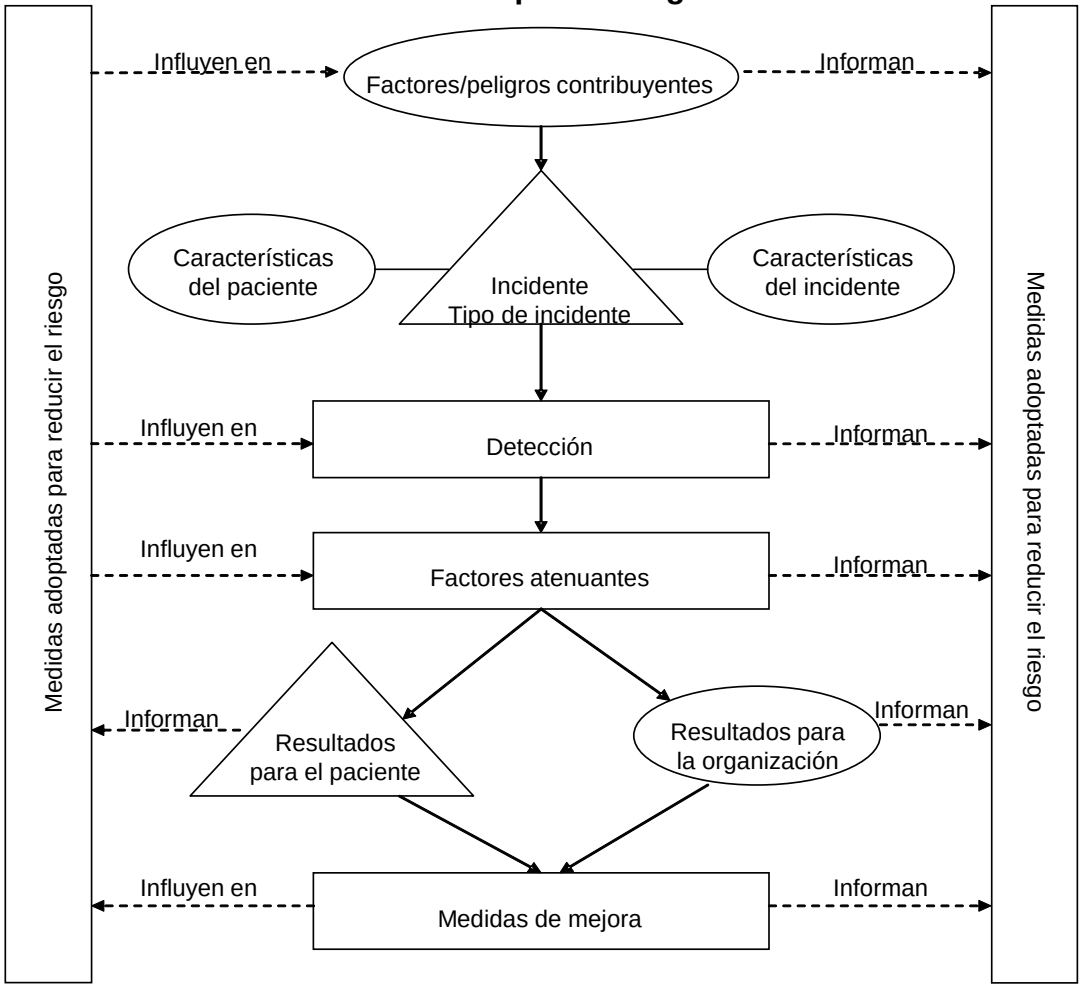
International Classification ICPS



Marco conceptual de la Clasificación Internacional para la Seguridad del Paciente



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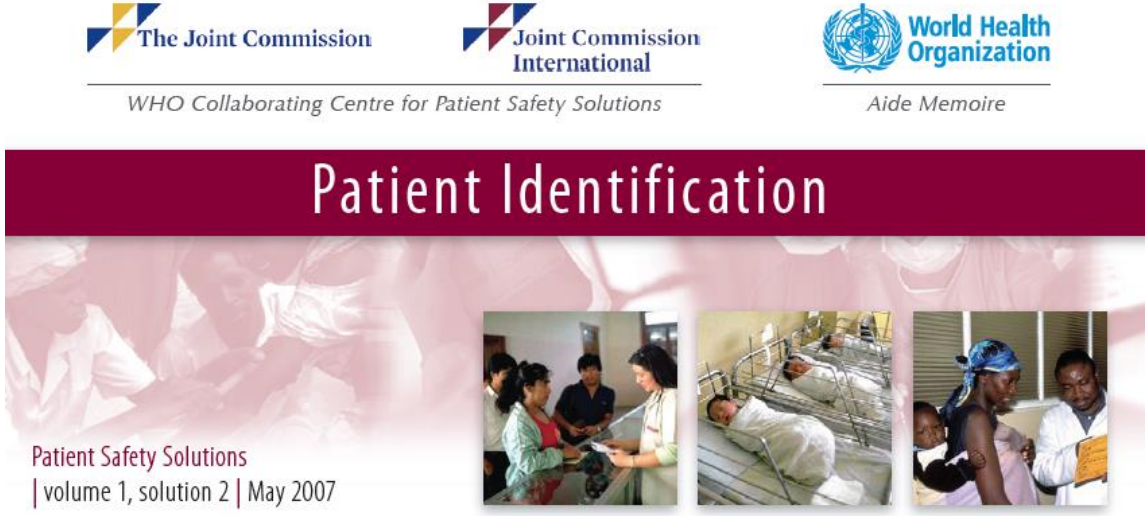
Patient Safety Solutions

- Nine patient safety solutions to reduce the toll of health care-related harm, launched on 2 May 2007
- Second set of 5-6 solutions in preparation to be delivered in 2008
- JCAHO-JCI WHO Collaborating Center on Patient Safety Solutions



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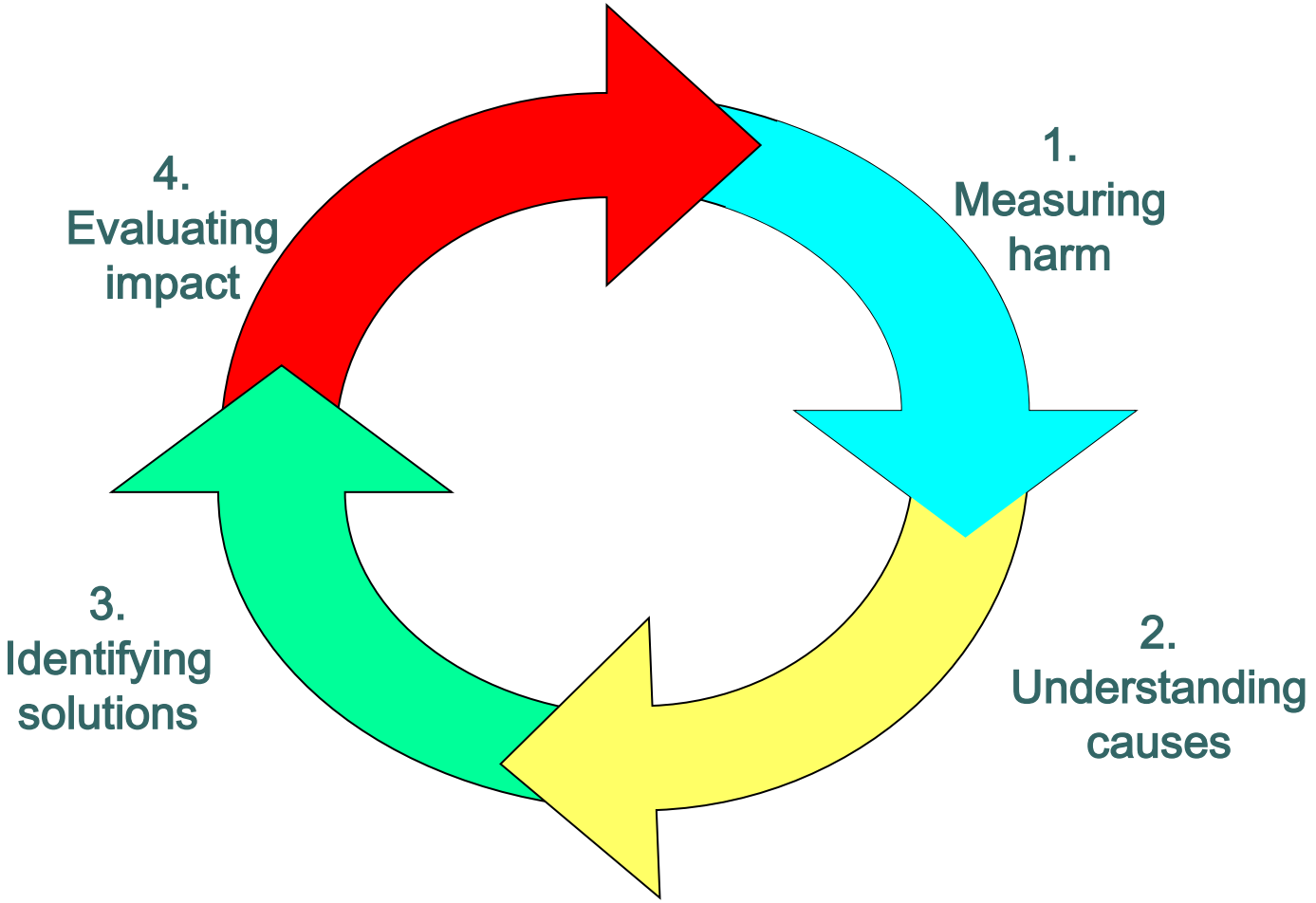
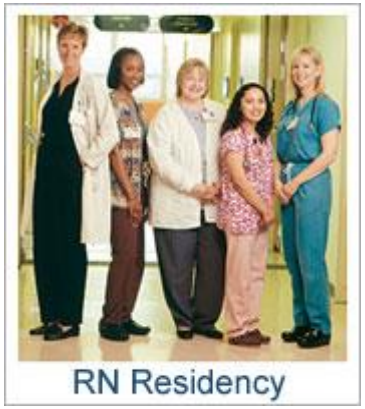
Research for patient safety



Education for Patient Safety

- Medical students
- Pharmacy Students
- Patients



RN Residency

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Matching Michigan

- Central venous Catheter associated infections
  - A five-item checklist developed to address the most common causes of ICU catheter-associated blood stream infection.
  - A comprehensive "change management strategy"
  - The change in infection rates itself was intensely monitored.
  - The participating ICUs reduced their catheter-associated BSI rates to 0%.
  - 1,500 lives saved and nearly $200 million.

Matching Michigan: WHO-Hopkins intervention package

- Development of a WHO-Hopkins Intervention package
  - intervention tools and change management strategies that are based on the Michigan work
  - adapted in other countries
- Initial work developed with the Ministry of Health of Spain.
  - The Ministry of Health and the Spanish *Sociedad Española de Medicina Intensiva, Critica y Unidades Coronarias, Grupo de Trabajo de Enfermedades Infecciosas (SEMICIUC)* are leading wide implementation of a national strategy based on the lessons drawn from "Michigan".
- This initiative can provide valuable lessons to the definition of the Alliance *Matching Michigan* Strategy.

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Safety Culture

- Patients first
- Leadership
- Individual Commitment
- Collaboration & Learning

Patient safety

In October 2004, WHO launched the World Alliance for Patient Safety in response to a World Health Assembly Resolution (2002) urging WHO and Member States to pay the closest possible attention to the problem of patient safety. The Alliance raises awareness and political commitment to improve the safety of care and facilitates the development of patient safety policy and practice in all WHO Member States. Each year, the Alliance delivers a number of programmes covering systemic and technical aspects to improve patient safety around the world.

Patient safety: Key issues


Patient Safety interview of the month by Sir Liam Donaldson


Clean Care is Safer Care: Country Campaigning Meeting


Patient safety fact file

PAST EVENTS

Second Technical Working Group Meeting - "Safe Surgery Saves Lives"
9-11 July 2007 - Geneva, Switzerland
More information

Regional Patient Safety Workshop on "Clean Care is Safer Care"

UPCOMING EVENTS

Patient Safety Research Shaping the European Agenda
24-26 September 2007 - Porto, Portugal
More information

View all upcoming events

ABOUT US

World Alliance for Patient Safety

PATIENT SAFETY NEWS

USA
June 2007
Sixth Quality Colloquium at Harvard University Announces Patient Safety Certificate Program
More information

USA
June 2007
Patients meet to promote mother and child health in the Americas
More information

France
May 2007
Patient safety activities: an overview
More information [pdf 66kb]

News archive

HIGHLIGHTS

Norway
National Unit for Patient Safety
More information

Institute for Healthcare Improvement