Patient Safety

Making health care safer

World Health Organization

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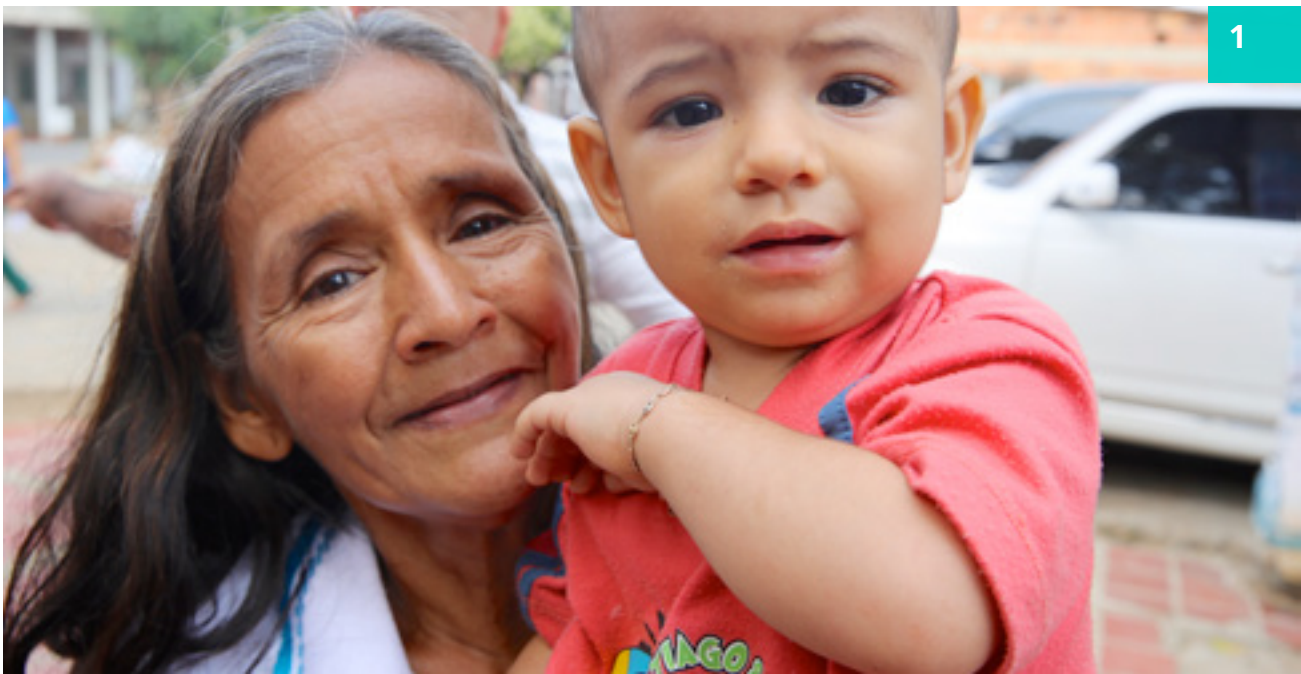
Patient safety – a global concern

Patient safety is a fundamental principle of health care. A number of high-income countries have published studies showing that significant numbers of patients are harmed during health care, either resulting in permanent injury, increased length of stay in health care facilities, or even death. According to a new study, medical errors are the third leading cause of death in the United States. In the United Kingdom, recent estimations show that on average, one incident of patient harm is reported every 35 seconds. Similarly, in low- and middle-income countries, a combination of numerous unfavourable factors such as understaffing, inadequate structures and overcrowding, lack of health care commodities and shortage of basic equipment, and poor hygiene and sanitation, contribute to unsafe patient care. A weak safety and quality culture, flawed processes of care, and disinterested leadership teams further weaken the ability of health care systems and organizations to ensure provision of safe health care.

Ensuring the safety of patients is a high visibility issue for those delivering health care - not just in any single country, but worldwide. The safety of health care is now a major global concern. Services that are unsafe and of low quality lead to diminished health outcomes and even to harm. The experience of countries that are heavily engaged in national efforts clearly demonstrates that, although health systems differ from country to country, many threats to patient safety have similar causes and often similar solutions. Treating and caring for people in a safe environment and protecting them from health care-related avoidable harm should be a national and international priority, calling for concerted international efforts.

Delivering safer care in complex, pressurized and fast-moving environments is one of the greatest challenges facing health care today. In such environments, things can often go wrong. The most important challenge in the field of patient safety must be how to prevent harm, particularly 'avoidable harm', to patients during treatment and care. All preventable errors can, and should be, avoided. But in order to provide high quality health services, the safety of each and every patient deserves to be given the highest priority.



The burden and impact of unsafe care

Every year, an inadmissible number of patients suffer injuries or die because of unsafe and poor quality health care. Most of these injuries are avoidable. The burden of unsafe care broadly highlights the magnitude and scale of the problem.

- It is commonly reported that around 1 in 10 hospitalized patients experience harm, with at least 50% preventability.
- In a study on frequency and preventability of adverse events, across 26 low- and middle-income countries, the rate of adverse events was around 8%, of which 83% could have been prevented and 30% led to death.
- It is estimated that 421 million hospitalizations take place in the world annually, and approximately 42.7 million adverse events occur in patients during those hospitalizations.
- Approximately two-thirds of all adverse events happen in low- and middle-income countries.

It is estimated that the cost of harm associated with the loss of life or permanent disability, which results in lost capacity and productivity of the affected patients and families, amounts to trillions of US dollars every year. Furthermore, the psychological cost to the patient and their family, associated with the losing a loved one or coping with permanent disability, is significant though more difficult to measure. Studies on direct medical costs associated with poor care show that additional hospitalization, litigation costs, infections acquired in hospitals, lost income, disability and medical expenses have cost some countries between US$ 6 billion and US$ 29 billion per year. Loss of trust in the system and loss of reputation and credibility in health services are additional forms of collateral damage caused by unsafe health care.

The evidence currently available shows that 15% of hospital expenditure in Europe can be attributed to treating safety accidents. It is estimated that the aggregate cost of harm, in terms of lost capacity and productivity of the affected patients and families, comes to trillions of US dollars every year. The cost of preventing these errors is insignificant in comparison. In the United States alone, focused safety improvements led to an estimated US$ 28 billion in savings in Medicare hospitals alone, between 2010-15.

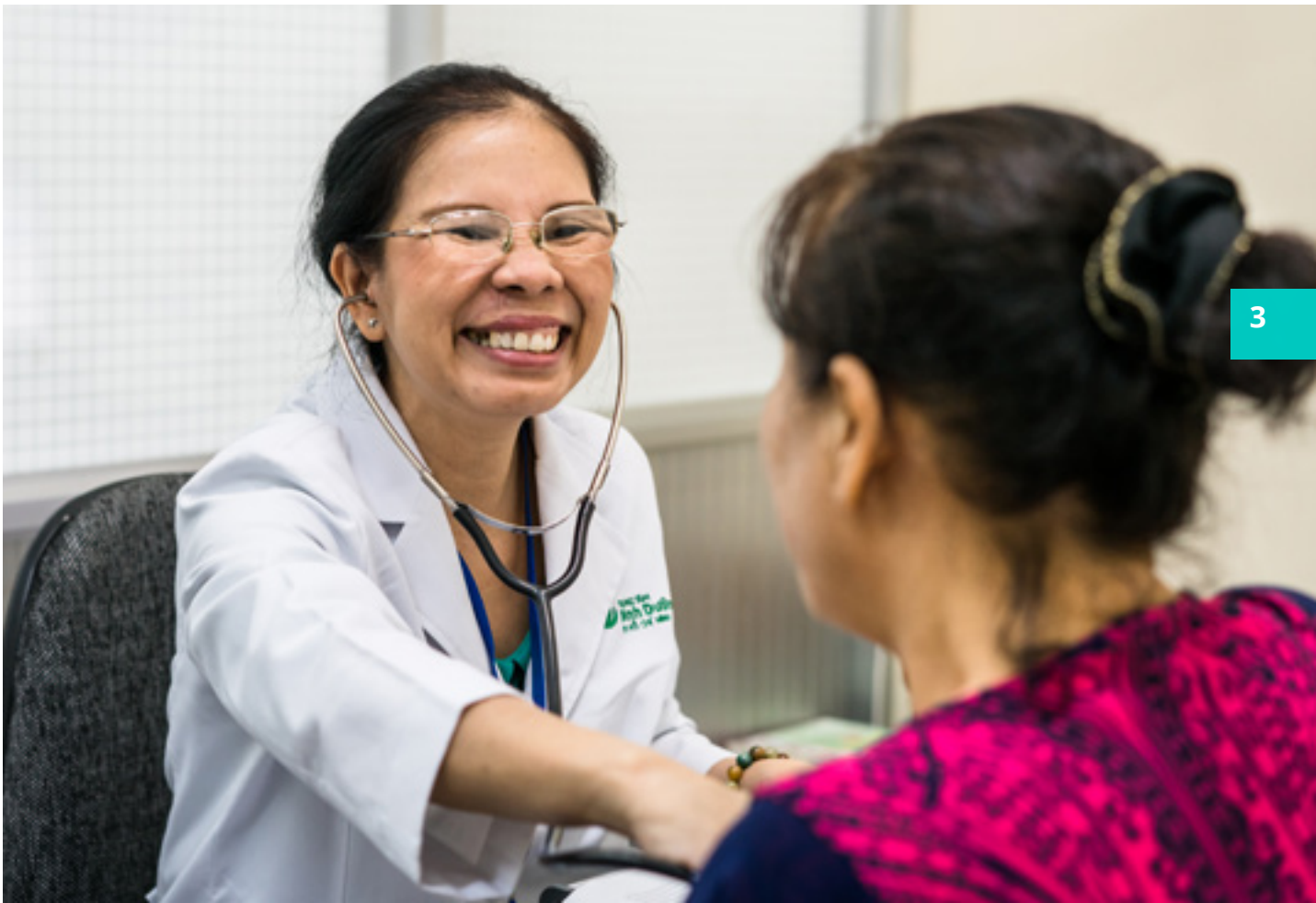
Medical errors occur right across the spectrum, and can be attributed to both system and human factors. The most common adverse safety incidents are related to surgical procedures (27%), medication errors (18.3%) and health care-associated infections (12.2%). Yet, in many places, fear around the reporting of errors is manifested within health care cultures, impeding progress and learning for improvement and error prevention.

The World Health Organization's work on patient safety

The global need for quality of care and patient safety was first discussed during the World Health Assembly in 2002, and resolution WHA55.18 on 'Quality of care: patient safety' at the Fifty-fifth World Health Assembly urged Member States to "pay the closest possible attention to the problem of patient safety". Since then, there have been several international initiatives, which have brought the importance of the matter to the attention of policy-makers in many countries.

However, there have been limited systemic improvements in the safety of health care globally, and in some situations efforts made have been unsustained and uncoordinated. In many countries, health services, where they are available, are of poor quality, thus endangering the safety of patients, compromising health outcomes, and this leads to lack of trust of the population in health services. Clear policies, organizational leadership capacity, data to drive safety improvements, skilled health care professionals and effective involvement of patients in their care, are all needed to ensure sustainable and significant improvements in the safety of health care.

The World Health Organization's (WHO) strategic objectives in the area of patient safety are to provide global leadership for patient safety and to harness knowledge, expertise and innovation to improve patient safety in health care settings. WHO's unique convening role at the global level provides a vehicle for improving patient safety and managing risk in health care through international collaboration, engagement and coordinated action between Member States, institutions, technical experts, patients, civil society, industry, as well as development partners and other stakeholders.



Our vision

A world where every patient receives safe health care, without risks and harm, every time, everywhere.

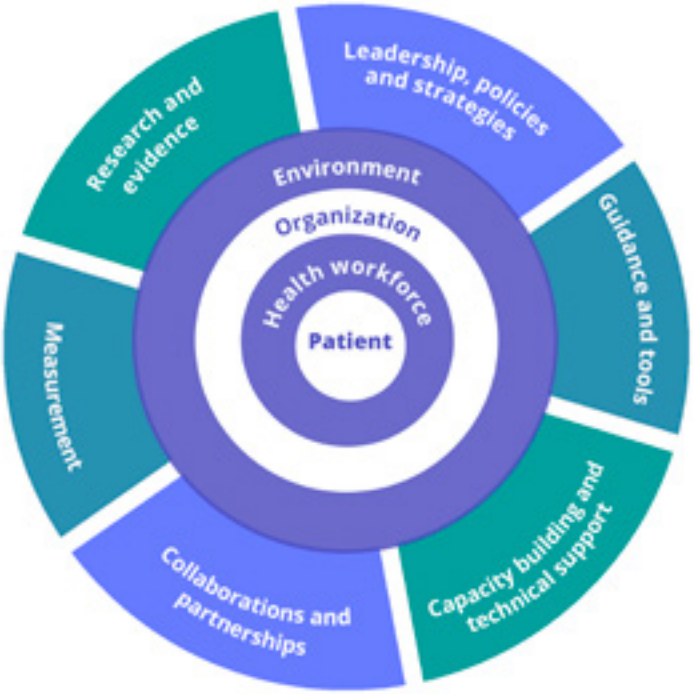
Our mission

To facilitate sustainable improvements in patient safety and managing risks to prevent patient harm.

Our approach

WHO's work on patient safety began with the launch of the World Alliance for Patient Safety, in 2004, and has evolved over time. The WHO Patient Safety and Risk Management unit has been created to coordinate, disseminate and accelerate improvements in patient safety and managing risks in health care to prevent patient harm worldwide.

Our approach to driving improvements



Expected outcomes

- **Improved patient safety**
- **Reduced risks and harm**
- **Better health outcomes**
- **Enhanced patient experience**
- **Lower costs**

Since 2002, improving patient safety has been mandated by successive global and regional resolutions. WHO has been instrumental in shaping the patient safety agenda worldwide by providing leadership, setting priorities, convening experts, fostering collaboration and creating networks, issuing guidance, facilitating change and building capacity, and monitoring trends. Placing the patient at the centre of improvement strategies for safer health care, WHO's work on patient safety is driving improvements through the following key strategic areas:

- Providing global leadership and fostering collaboration
- Developing guidelines and tools, and building capacity
- Engaging patients and families for safer health care
- Monitoring improvements in patient safety.

Providing global leadership and fostering collaboration

Medication Without Harm

WHO's third Global Patient Safety Challenge

One of the concrete ways in which WHO facilitates improvements on the ground is through a 'Global Patient Safety Challenge'. The Challenge identifies a patient safety burden that poses a major and significant risk to patient health and safety, and then develops front-line interventions to tackle the issue. WHO provides leadership and guidance, in collaboration with Member States, stakeholders and experts, to develop and implement interventions and tools to reduce risk, improve safety and facilitate beneficial change. The two previous challenges, *Clean Care is Safer Care and Safe Surgery Saves Lives,* sparked action to reduce health care infection and risks associated with surgery, respectively.

Globally, the cost associated with medication errors is US$ 42 billion each year, almost 1% of global expenditure on health.

WHO has initiated its third Global Patient Safety Challenge: *Medication Without Harm*, to address a number of issues related to medication safety.

This Challenge aims to reduce medication-related harm caused by unsafe medication practices and errors. The Challenge focuses on improving medication safety by strengthening the systems for reducing medication errors and avoidable medication-related harm, with the goal to

Reduce the level of severe, avoidable harm related to medications by 50% over 5 years, globally.

The Challenge was launched in March 2017 during the Second Global Ministerial Summit on Patient Safety in Bonn, Germany, in the presence of global health leaders and policy-makers. This event secured political support with commitments from health ministers to act as catalysts for change.

Countries are requested to prioritize taking action on medication safety, designate leaders to drive action and devise their own tailored programmes centred on local priorities. WHO will lead the process of change by providing support to countries for developing national programmes, instigating large-scale international research, providing guidance and developing practical tools for front-line health workers and for patients.

In driving forward the third Global Patient Safety Challenge, WHO will provide support with action in 10 key areas:

1. to lead action to progress the key components of the Challenge;

2. to facilitate country programmes;

3. to commission expert reports for planning and guiding actions to be taken;

4. to develop strategies, guidelines, plans and tools on safe medication practices;

5. to publish a strategy setting out research priorities and mobilize resources for international research on hospital admissions resulting from medication-related adverse events;

6. to hold regional launches to secure political commitment, as a follow-up from the global launch;

7. to create communication and advocacy strategies, alongside a global campaign with promotional and educational materials for in-country use;

8. to ensure patients and families are closely involved in all aspects of the Challenge, including in the development of patient tools;

9. to monitor and evaluate impact of the Challenge;

10. to mobilize resources to enable successful implementation of the Challenge.

WHO will also seek to develop a greater understanding of medication-related harm in low- and middle-income countries and adapt the Challenge to the varying needs of diverse settings.

A real story of harm from a medication error

A couple took their two-week-old baby girl for a routine check-up. The