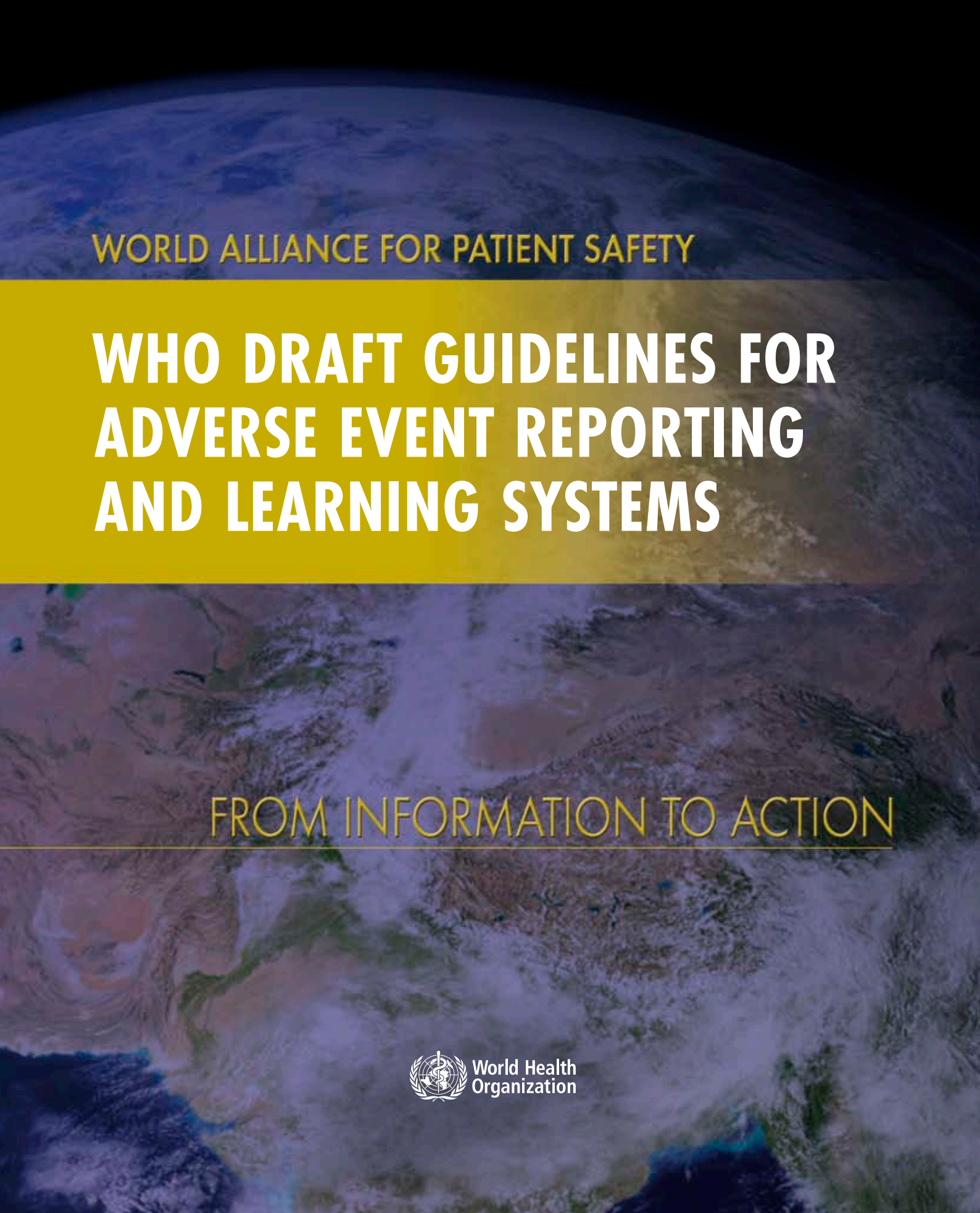
WORLD ALLIANCE FOR PATIENT SAFETY
WHO DRAFT GUIDELINES FOR ADVERSE EVENT REPORTING AND LEARNING SYSTEMS
FROM INFORMATION TO ACTION
World Health Organization

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This document reflects collaborative effort across WHO, led by the Evidence and Information for Policy Cluster, with significant input from the staff at WHO regional offices and from partners working in collaboration with WHO worldwide.

FOREWORD

Imagine a jet aircraft which contains an orange coloured wire essential for its safe functioning. An airline engineer in one part of the world doing a pre-flight inspection spots that the wire is frayed in a way that suggests a critical fault rather than routine wear and tear. What would happen next? I think we know the answer. It is likely that – probably within days – most similar jet engines in the world would be inspected and the orange wire, if faulty, would be renewed.

When will health-care pass the orange-wire test?

The belief that one day it may be possible for the bad experience suffered by a patient in one part of the world to be a source of transmitted learning that benefits future patients in many countries is a powerful element of the vision behind the WHO World Alliance for Patient Safety.

The most important knowledge in the field of patient safety is how to prevent harm to patients during treatment and care. The fundamental role of patient safety reporting systems is to enhance patient safety by learning from failures of the health care system. We know that most problems are not just a series of random, unconnected one-off events. We know that health-care errors are provoked by weak systems and often have common root causes which can be generalized and corrected. Although each event is unique, there are likely to be similarities and patterns in sources of risk which may otherwise go unnoticed if incidents are not reported and analysed.

These draft guidelines are a contribution to the Forward Programme 2005 of the World Alliance for Patient Safety. The guidelines introduce patient safety reporting with a view to helping countries develop or improve reporting and learning systems in order to improve the safety of patient care. Ultimately, it is the action we take in response to reporting – not reporting itself – that leads to change.

Reporting is fundamental to detecting patient safety problems. However, on its own it can never give a complete picture of all sources of risk and patient harm. The guidelines also suggest other sources of patient safety information that can be used both by health services and nationally.

The currency of patient safety can only be measured in terms of harm prevented and lives saved. It is the vision of the World Alliance that effective patient safety reporting systems will help to make this a reality for future patients worldwide.

Sir Liam Donaldson

Chair
World Alliance for Patient Safety

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