International Journal of Risk & Safety in Medicine 19 (2007) 171–173
IOS Press

WHO News

WHO Collaborating Centre for Patient Safety Releases [1]

Nine life-saving Patient Safety Solutions

Washington, DC, USA – May 2, 2007

Nine solutions to prevent health care errors that harm millions of people daily throughout the world were unveiled today by the World Health Organization's (WHO) Collaborating Centre for Patient Safety Solutions. The nine *Patient Safety Solutions* are available for use by WHO Member States.

The *Patient Safety Solutions* address the issues of look-alike, sound-alike medication names; correct patient identification; hand-over communications; correct procedure at the correct body site; control of concentrated electrolyte solutions; medication accuracy; catheter and tubing mis-connections; needle reuse and injection device safety; and hand hygiene. The basic purpose of the solutions is to guide the re-design of care processes to prevent inevitable human errors from actually reaching patients.

In 2005, WHO designated The Joint Commission and Joint Commission International as its Collaborating Centre on Patient Safety Solutions. The Joint Commission International Center for Patient Safety operationalized this effort by identifying widespread problems and challenges to safe care, identifying promising solutions, and vetting them through an extensive field review process that garnered feedback from health care providers, practitioners, and other experts from more than 100 countries.

"Patient safety is now recognized as a priority by health systems around the world", says Sir Liam Donaldson, chair of the Alliance, chief medical officer for England, and chief medical adviser for the Government of the United Kingdom of Great Britain and Northern Ireland. "The *Patient Safety Solutions* program of work is addressing several vital areas of risk to patients. Clear and succinct actions contained in the nine solutions have proved to be useful in reducing the unacceptably high numbers of medical injuries around the world".

"These solutions offer to WHO Member States a major new resource to assist their hospitals in avoiding preventable deaths and injuries", says Dennis S. O'Leary, MD, president, The Joint Commission. "Countries around the world now face both the opportunity and the challenge to translate these solutions into tangible actions that actually save lives".

"These *Patient Safety Solutions* were designed through a truly international collaborative effort, and represent what has been learned internationally about where, how and why certain adverse events occur", says Karen H. Timmons, president and chief executive officer, Joint Commission International. "A critical component of their development has involved inclusion of input from patients and their families who have experienced preventable harm".

The individual *Patient Safety Solutions* identify the following challenges and strategies:

[1] To view this press release and complete press kit online go to : www.jointcommissioninternational.org/solutions

- **Look-alike, sound-alike medication names** – Confusing drug names is one of the most common causes of medication errors and is a worldwide concern. With tens of thousands of drugs currently on the market, the potential for error created by confusing brand or generic drug names and packaging is significant. The recommendations focus on using protocols to reduce risks and ensuring prescription legibility or the use of preprinted orders or electronic prescribing.
- **Patient identification** – The widespread and continuing failures to correctly identify patients often leads to medication, transfusion and testing errors; wrong person procedures; and the discharge of infants to the wrong families. The recommendations place emphasis on methods for verifying patient identity, including patient involvement in this process; standardization of identification methods across hospitals in a health care system; and patient participation in this confirmation; and use of protocols for distinguishing the identity of patients with the same name.
- **Communication during patient hand-overs** – 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.
- **Performance of correct procedure at correct body site** – Considered totally preventable, cases of wrong procedure or wrong site surgery are largely the result of miscommunication and unavailable, or incorrect, information. A major contributing factor to these types of errors is the lack of a standardized preoperative process. The recommendations to prevent these types of errors rely on the conduct of a preoperative verification process; marking of the operative site by the practitioner who will do the procedure; and having the team involved in the procedure take a 'time out' immediately before starting the procedure to confirm patient identity, procedure, and operative site.
- **Control of concentrated electrolyte solutions** – While all drugs, biologics, vaccines and contrast media have a defined risk profile, concentrated electrolyte solutions that are used for injection are especially dangerous. The recommendations address standardization of the dosing, units of measure and terminology; and prevention of mix-ups of specific concentrated electrolyte solutions.
- **Assuring medication accuracy at transitions in care** – Medication errors occur most commonly at transitions. Medication reconciliation is a process designed to prevent medication errors at patient transition points. The recommendations address creation of the most complete and accurate list of all medications the patient is currently taking-also called the 'home' medication list; comparison of the list against the admission, transfer and/or discharge orders when writing medication orders; and communication of the list to the next provider of care whenever the patient is transferred or discharged.
- **Avoiding catheter and tubing mis-connections** – The design of tubing, catheters and syringes currently in use is such that it is possible to inadvertently cause patient harm through connecting the wrong syringes and tubing and then delivering medication or fluids through an unintended wrong route. The recommendations address the need for meticulous attention to detail when administering medications and feedings (i.e., the *right* route of administration), and when connecting devices to patients (i.e., using the *right* connection/tubing).

- **Single use of injection devices** – One of the biggest global concerns is the spread of Human Immunodeficiency Virus (HIV), the Hepatitis B Virus (HBV), and the Hepatitis C Virus (HCV) because of the reuse of injection needles. The recommendations address the need for prohibitions on the reuse of needles at health care facilities; periodic training of practitioners and other health care workers regarding infection control principles; education of patients and families regarding transmission of blood borne pathogens; and safe needle disposal practices.
- **Improved hand hygiene to prevent health care-associated infection (HAI)** – It is estimated that at any point in time more than 1.4 million people worldwide are suffering from infections acquired in hospitals. Effective hand hygiene is the primary preventive measure for avoiding this problem. The recommendations encourage the implementation of strategies that make alcohol-based hand-rubs readily available at points of patient care; access to a safe, continuous water supply at all taps/faucets; staff education on correct hand hygiene techniques; use of hand hygiene reminders in the workplace; and measurement of hand hygiene compliance through observational monitoring and other techniques.

The *Patient Safety Solutions* were developed with the assistance of an International Steering Committee of patient safety experts and patient representatives, as well as Regional Advisory Councils in Europe, the Middle East and the Asia-Pacific region. A major international field review of the proposed solutions was also conducted to gather feedback from leading patient safety entities, accrediting bodies, ministries of health, international health professional organizations and practitioners, patients, and other experts.

For more information or to view the complete *Patient Safety Solutions*, please access www.jointcommissioninternational.org/solutions