

High 5s: Action on Patient Safety


In support of the work of WHO Patient Safety Programme



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High 5s

- Launched in 2007 by the World Health Organization (WHO) to address concerns of patient safety around the world
- A global patient safety collaboration of:
 - 9 countries
 - WHO Collaborating Centre for Patient Safety
 - WHO Patient Safety Programme
 - other agencies



High 5s

Derives its name from the original intent to reduce the frequency of:

- 5 problems
- 5 countries
- 5 years

High 5s: Mission

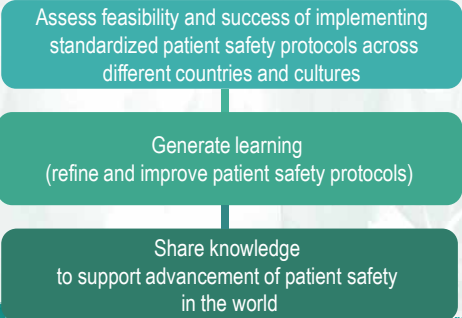
The Mission of the High 5s Project is to facilitate implementation and evaluation of standardized patient safety solutions:

- within a global learning community
- to achieve measurable, significant and sustainable reductions in high risk patient safety problems




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High 5s scope

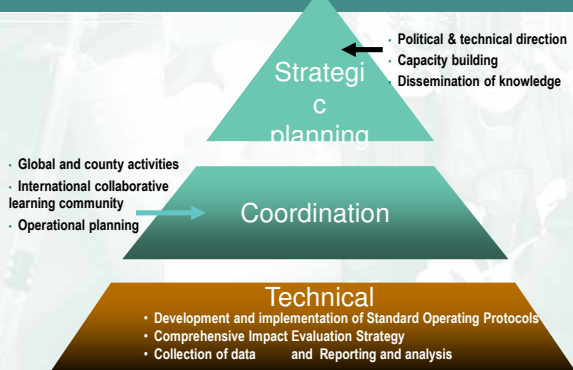


- Assess feasibility and success of implementing standardized patient safety protocols across different countries and cultures
- Generate learning (refine and improve patient safety protocols)
- Share knowledge to support advancement of patient safety in the world

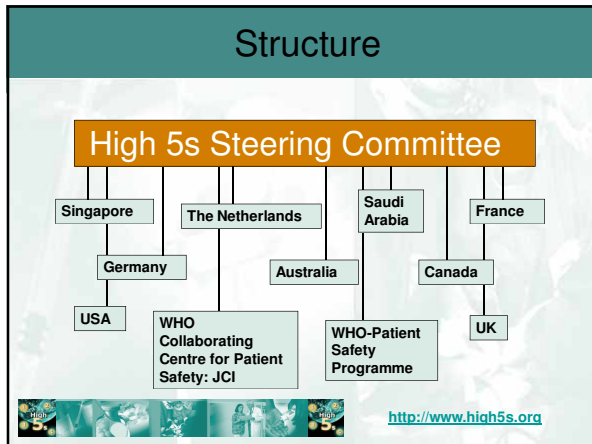


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Components of High 5s



- Strategic planning**
 - Political & technical direction
 - Capacity building
 - Dissemination of knowledge
- Coordination**
 - Global and county activities
 - International collaborative learning community
 - Operational planning
- Technical**
 - Development and implementation of Standard Operating Protocols
 - Comprehensive Impact Evaluation Strategy
 - Collection of data and Reporting and analysis



- ## Contributions of members
- **WHO Patient Safety:** policy dialogue, technical, advocacy, country engagement
 - **WHO Collaborating Centre:** coordinate activities, organise meetings, develop SOPs and evaluation framework, establish learning communities, undertake analyses
 - **Countries:** coordinate activities, develop SOPs, recruit and support hospitals, implement and evaluate, support data collection
 - Supported by:
 - Participating countries (national)
 - WHO, WHO CC, U.S. Agency for Healthcare Research and Quality, Commonwealth Fund (global)
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- ## Overall achievements to date
1. Gained **ministerial support**
 2. Identified **Lead Technical Agencies** in each participating country
 3. Developed and refined:
 - **Standard Operating Protocols** to address five challenging safety problems
 - **Implementation strategy** (for project and facilities)
 - **Impact Evaluation Strategy**
 4. Established **learning communities and information management system**
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- ## Lead Technical Agencies
- Specialised national agencies and institutes
 - Departments in Ministries of Health
 - Each LTA is recruiting participating hospitals (min. 10 hospitals/SOP)
- 2. LTAs identified: 2007 and 2008**

Lead Technical Agencies

- **Australia:** Australian Commission in Safety and Quality in Healthcare
- **Canada:** Canadian Patient Safety Institute
- **France:** National Authority for Health -HAS
- **Germany:** German Coalition for Patient Safety
- **The Netherlands:** Dutch Institute for Healthcare Improvement –CBO
- **Saudi Arabia:** Ministry of Health
- **Singapore:** Ministry of Health
- **United Kingdom:** National Patient Safety Agency
- **United States of America:** Agency for Healthcare Research and Quality



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Standard Operating Protocols

- 3 SOPs completed
- Implementation of SOPs to start in early 2010 for next 4-5 years
- Evaluation framework being finalized

3. SOPs and Evaluation framework finalized: 2009

Standard Operating Protocols

3 SOPs finalised:

- Managing Concentrated Injectable Medicines
- Assuring Medication Accuracy at Transitions in Care
- Performance of Correct Procedure at Correct Body Site

2 SOPs deferred to a later date:

- Communication failures during patient handovers (late 2010)
- Addressing health care-associated infection



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Learning communities & Information Management System

- Learning communities growing (LTAs, hospitals, experts)

Links:

- Potential of distance learning via webinars
- Wiki IMS for wide collaboration
- TC discussions

4. LC growing, IMS established: 2009

IMS: Wiki platform

Welcome to the High 5s Project Website

www.high5s.org finalised: 2009

High 5s Project
Name and password:

Log in

Forgot your password?

or log in if you have any questions: www.high5s.org

The High 5s Project was launched by the World Health Organization (WHO) in 2009 to address continuing, high concerns about patient safety around the world. The High 5s initiative derives from the Project's original intent to significantly reduce the frequency of 5 challenging patient safety problems in 5 countries over 5 years.

The Mission of the High 5s Project is to facilitate implementation and evaluation of standardized patient safety solutions within a global learning community to achieve measurable, significant and sustainable reductions in challenging patient safety problems.

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The High 5s Project is a patient safety problem-solving group of countries and the WHO Collaborating Centre for Patient Safety, in support of the World Health Organization (WHO) Patient Safety Programme. Please visit the High 5s Project website for more information.

THANK YOU !



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High 5s Project Design



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Why This Project

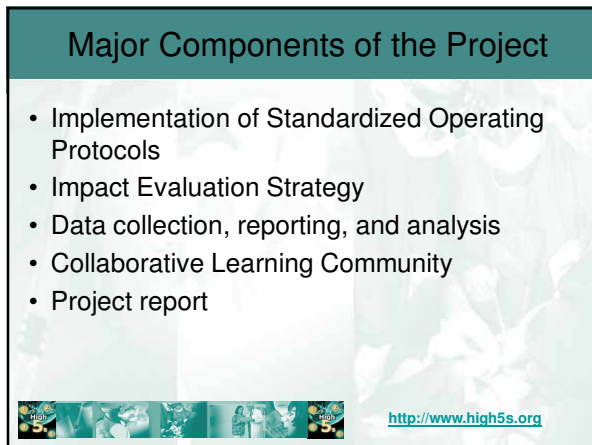
- Widespread patient safety concerns
- Commonality of problems
- Solutions: necessary but not sufficient
- Taking on the standardization challenge



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Major Components of the Project

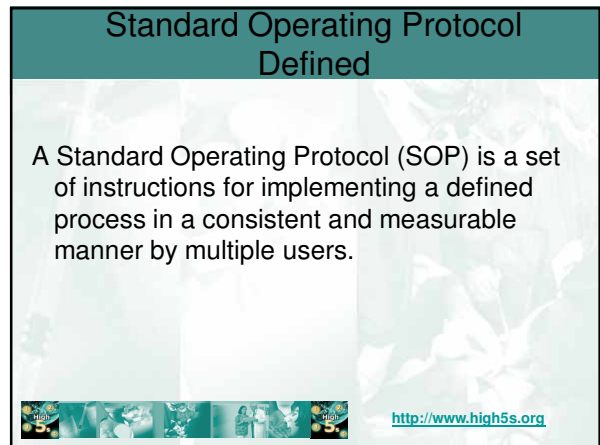
- Implementation of Standardized Operating Protocols
- Impact Evaluation Strategy
- Data collection, reporting, and analysis
- Collaborative Learning Community
- Project report



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Standard Operating Protocol Defined

A Standard Operating Protocol (SOP) is a set of instructions for implementing a defined process in a consistent and measurable manner by multiple users.



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High 5s Standardized Operating Protocols

- Managing Concentrated Injectable Medicines (U.K.)
- Assuring Medication Accuracy at Transitions in Care (Canada)
- Performance of Correct Procedure at Correct Body Site (U.S.)
- Communication During Patient Care Handovers (Australia)
- Improved Hand Hygiene to Prevent Health Care-Associated Infections



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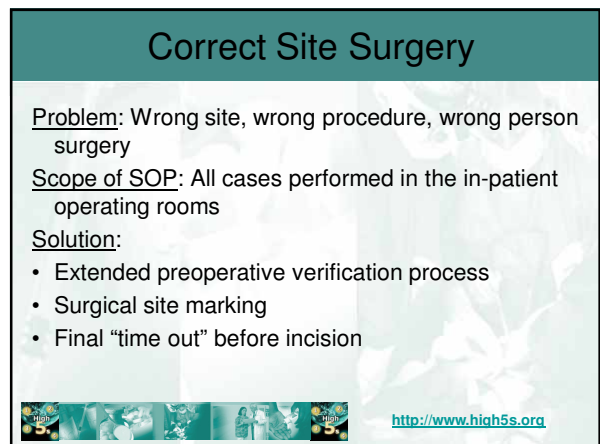
Correct Site Surgery

Problem: Wrong site, wrong procedure, wrong person surgery

Scope of SOP: All cases performed in the in-patient operating rooms

Solution:

- Extended preoperative verification process
- Surgical site marking
- Final “time out” before incision



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Medication Reconciliation

Problem: Miscommunications about patient medications among caregivers

Scope of SOP: Patients age 65 and older admitted through the Emergency Department to in-patient units



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Medication Reconciliation (cont.)

Solution:

- "Best possible medication history" on admission
- Compare with admission orders
- Reconcile discrepancies
- Repeat process at all patient care transitions across the care continuum



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Concentrated Injectable Medicines

Problem: Inadvertent injection of undiluted concentrated medicines

Scope of SOP:

- Concentrated potassium chloride solution
- Sodium heparin >1000 units/milliliter
- Injectable morphine preparations



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Concentrated Injectable Medicines (cont.)

Solution:

- Minimize storage/preparation of concentrates on clinical units
- Encourage ready-to-use products
- Standardize procedure if concentrated medicines must be used on clinical units



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Evaluation Plan

- Identify and apply process and outcome measures for each Protocol
- Evaluate Protocol implementation and, over time, modify Protocols as appropriate
- Develop and apply an Event Analysis Framework, including the identification and use of Protocol-specific trigger events
- Conduct baseline and periodic organization culture surveys



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SOP Implementation Evaluation

- Determine whether an SOP can be implemented as it was designed to be implemented
- Determine whether the SOPs appear to be effective in preventing the targeted adverse events
- Determine the potential portability of the SOPs



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Performance Measurement Questions

- To what extent does the implementation of the SOPs result in accurate adherence to the protocols?
- To what extent does the implementation of the SOPs impact the specific targeted patient outcomes?



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Potential Event Analysis Targets

- SOP-related adverse events
- SOP-related “near-misses”
- SOP-related “trigger events” (prompts)



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Tasks Completed Since Fall 2008

- Preparation of an information brief regarding the Correct Site Surgery SOP and the WHO Surgical Safety Checklist
- Finalization of the SOP-specific performance measures
- Finalization of Event Analysis Framework



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Tasks Completed (cont.)

- Selection of AHRQ harm scale to judge event severity
- Creation of hospital demographic profile
- Creation of data quality monitoring protocol
- Creation of Information Management System to support the Project



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Tasks Completed (cont.)

- Determination of data transmission pathways and related privacy protections
- Development of SOP-specific implementation tool kits
- Finalization of Collaborating Centre, LTA and hospital roles and responsibilities



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Project Challenges

- Standardization across diverse countries
- Language barriers
- Competition with existing in-country project priorities
- Concerns about control of project results
- Project Launch



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. . . And In Conclusion



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NHS
National Patient Safety Agency

High 5s Project
England and Wales


Kate Beaumont
Head of NHS and Patient Engagement
National Patient Safety Agency
Catherine.beaumont@npsa.nhs.uk



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The Standard Operating Protocols (SOPs)


- Correct procedure at correct body site (Canada)
- Assuring medication accuracy at transfers in care (USA)
- **Prevention of high concentration injectable medication errors (UK – NPSA)**



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Description of patient safety problem


- Concentrated injectable medicines have been involved in medication incidents resulting in death or serious harm.
- These have been frequently caused by:
 - Mis-selection of the wrong product due to look-a-like labelling and packaging, where concentrated injectable medicines are mis-selected for other injectable medicines
 - Dose and rate of administration errors
 - This may involve incorrect calculation, measurement and dilution.



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Concentrated injectable medicines included

- Concentrated potassium chloride solution.
- Sodium heparin >1,000 units/ml.
- Injectable morphine preparations.
- Other concentrated injectable medicines in addition to those listed above may be included e.g. insulin/diamorphine (but measurement data will not be required to be submitted)



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NHS
National Patient Safety Agency

PATIENT SAFETY ALERT

PROBLEM:
Research in UK and elsewhere has identified a risk to patients from errors occurring during intravenous administration of potassium solutions. Potassium chloride concentrate solution can be fatal if given inappropriately.


ACTION FOR NHS BY 31 OCTOBER 2002:
This alert sets out action, including initial action in the following areas:

1. Storage and handling of potassium chloride concentrate and other strong potassium solutions
2. Preparation of dilute solutions containing potassium
3. Prescription of solutions containing potassium
4. Checking use of strong potassium solutions in clinical areas

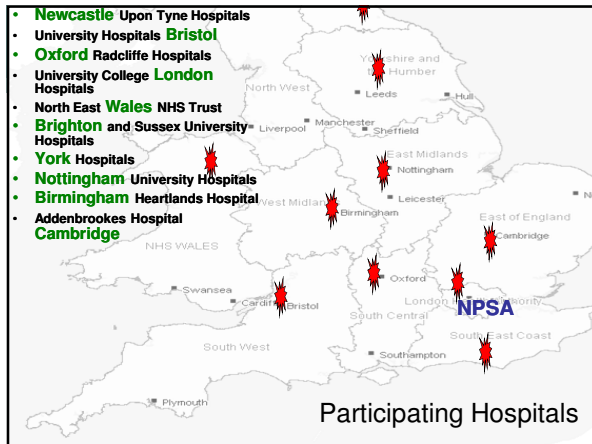
For the attention of:
Chief Executives of NHS Trusts and Primary Care Trusts

For action by:
Chief Pharmacists and pharmaceutical advisers in NHS Trusts and Primary Care Trusts

For information to:
Regional Directors of Health and Social Care
Chief Executives of Strategic Health Authorities
Directors of Public Health: Regional, SHA, PCT
Medical Directors
Directors of Nursing
Risk Managers
Lead Consultants/Clinical Directors – critical care areas
Communications Leads
Patient Advice and Liaison Service (PALS)



Date: 23 July 2002



What is required of participating trusts?

- Identification of 2 project leads (pharmacist and patient safety lead) and attendance at in-country training *June* ✓
- Set up project group *July – September* ✓
- Establish lists of authorised and non-authorised clinical areas ✓
- Completion of hospital demographics on the High 5s Wiki *September* ✓
- Pre-test of the tools and processes *September/October*
- Self-reported narrative at 3/12 and quarterly thereafter

What is required of participating trusts?

- Begin implementation with pilot *December*
- Measurement of the process and outcomes and monthly aggregation of data *from January 2010*
- Sending aggregate data by email to NPSA (ensuring no patient identifiable information) *from January 2010*
- Event analysis (Root Cause Analysis) on incidents related to the SOP *as they occur, NPSA to discuss and support on individual basis*
- Case note review monthly to look for 'prompts' *from January 2010*
- Participating in interviews

Benefits to participating trusts

- National recognition as one of group of exemplar patient safety organisations
- Participation in international patient safety community of practice
- Participation in international safety culture evaluation for whole organisation (or part of if preferred) with analysis and report provided
- Improved patient care and patient safety through using systematic processes for implementation of best practice
- Support with implementation of existing NPSA national guidance
- Refresher RCA training if desired

What have we learned so far?

- The culture survey – big selling point but – cost issues encountered, paper or web issues, agreeing UK version all takes lots of time
- Need for budget and significant support for project from trust and top level buy-in, competes with lots of other safety initiatives – one trust has pulled out
- Getting the balance right – evaluation vs implementation – monthly measurement, monthly case note review, etc. - data quality requirements are a step too far...
- Most trusts only prepared to review 20 case notes monthly – most doubt they will find adverse events



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What have we learned so far?

- It needs a lot of support from LTA – NPSA pharmacy staff visiting monthly
- Definitions - ? 'temporarily' authorised areas/ 'named patient supply', differences in harm scale, which patient sample for monthly review, delay/omission measure?
- Who collects the data? Easier when all areas covered by a ward pharmacist
- Dependent on availability of ready diluted products



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But we're on track!

- Ten trusts are ready to go...



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The World Alliance for Patient Safety *High 5s* initiative

The situation in France

Charles Bruneau,
Haute Autorité de Santé



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Commitment by the French Health Ministry and by HAS :

Objectives

- Coherence with national priorities
- Coherence with institutional priorities (e.g. accreditation program for HCOs, accreditation program for physicians)
 - The topics of the SOPs
 - The methods of assessment
- The imperative of impact measurement of organisational practices



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The Standard Operating Protocols selected

- **Managing Concentrated Injectable Medicines (UK)**
- ***Assuring Medication Accuracy at Transitions in Care (Canada)***
- ***Performance of Correct Procedure at Correct Body Sites (US)***
- Communication During Patient Care Handovers (Australia)
- Improved Hand Hygiene to Prevent Health Care Associated Infections



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The Surgical Checklist (in France)

At the initiative of HAS, representatives of professionals working in operating rooms in association with patients representatives adapted this checklist to the french context

AFU	FHP
CFAR	FNCLCC
CISS	FIA
Collège de neurochirurgie	FORAP
Conférence Présidents CME-CHU	GYNERISQ
Conférence Présidents CME-CH	LIEN
Conférence Présidents CME – PSPH	ORTHORISQ
Conférence Présidents CME – hosp priv.	PLASTIRISQ
CNC	SFAR
CNGOF	SFCTC
FCVD	SNIA
FEHAP	UNAIBODE
FHF	VASCURISQ



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Assuring Medication Accuracy at Transitions in Care (in France)

A medication error reduction practice currently experimented in the context of WP 4 of the project EUNetPaS

A network involving the 27 Member States of the European Community and piloted by HAS

Four Work Packages : culture, education, reporting and medication errors



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Assuring Medication Accuracy at Transitions in Care (in France)

- A large emphasis on pharmacovigilance activities
- Less on professional practices relative to medication safety
- Evidence of gaps in continuity of care between the ambulatory and hospital sectors



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The Lead Technical Agency

- Haute Autorité de Santé :
 - Mission of International Affairs
 - Support of the directions
- Regional quality and safety networks :
 - CEPPrAL (Rhônes Alpes): Correct procedure at correct site
 - EVALOR (Lorraine): Medication reconciliation
- A distribution of roles defined by a contractual agreement



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The implementation steps

- A pretest
- Recruitment of hospitals
- Training of professionals
- Piloting and implementation in hospitals
- Collection of data and event analysis
- Validation of data
- Transmission of data to the OMS centre and feedback to the hospitals every 3 months
- An annual report by each hospital



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Recruitment of hospitals

- A press release
- Information and links on the web sites of the LTA (HAS and regional structures)
- A dossier for the hospitals for each SOP (in draft form including translated documents)
- Basic selection criteria
- A « cahier des charges »
- Active contacts of hospitals by the regional structures
- Manifestations of interest but no formal agreement



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Valorisation for hospitals

- Participation to a learning international and national community
- Valorisation in the accreditation and clinical practice appraisal programs of HAS
- Access to validated documents and methodology
- Regional valorisation through contracts between hospitals and the Regional Agencies for Health
- Academic valorisation



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Implementation in HCOs

- **Pretest in 2 hospitals :**
 - Medication reconciliation: CH de Lunéville
 - Correct procedure at correct body site: CLCC Léon Bérard
- **Training of professionals from participating hospitals**
 - December or January 2010



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A communication strategy to be developed comprising

- An official launch
- National and SOP specific pilot committees
- The French National Platform on patient safety
- Annual national meetings and updates
- Dissemination of lessons learned on a regular basis



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High 5's

an (un)limited approach for
Medication Accuracy at Transitions in Care

Drs. Yvonne Salfischberger, MSc, senior advisor, manager patientsafety
CBO, Dutch Institute for health care improvement



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- Why are we involved in the High 5's ?
- Is High 5's suitable with our in country infrastructure and initiation of activities?
- What are our preparations?
- How did we recruit hospitals?



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CBO:

Dutch institute for health care improvement

- CBO has been active in the area of quality and healthcare for 30 years
- We give our attention to health care organizations, caregivers, but most of all to the patient
- Our organization supports and coaches in actually achieving quality improvement in care.



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Why are we involved...

- CBO ('technical agency') from 2006 in the preparations of the High 5's project
- Ministry of Health signed Statement of Intent
- As an observer & funded by the ministry of health member steering group
- Believe in a mundial approach towards patient safety problems & learn from eachother & together develop innovative methods to reduce harm



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In country infrastructure and initiation of activities.

- National safety program asks hospitals to develop a safety management program and implement 10 interventions
- Medication Accuracy at Transitions in Care
- Implementation of the Dutch guidelines for transfer of medication (2010)
- Change management, which is still difficult
- Experience in High 5's is useful for all Dutch hospitals



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Top-class sport



- Adoption of Best practices is still a challenge
- Gap: what we know and what we do
- So.....developing & evaluating knowledge for effective implementation methods is very important



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Our preparations, achievements , challenges;

not work morebut.....different



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Breakthrough

- The Breakthrough project focuses on medication reconciliation in 10 hospitals
- The High 5's SOP med. rec. is used as the 'Best Practice'.
- Practice in Canada shows: how you can do it that is feasible..... and which has good results
- During a period of twelve months, 10 hospital teams worked together supervised and trained by CBO, together with experts from the field



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Recruiting hospitals

- No big problem!
- What is on their agenda?
- They have their own ambition to make care safer
- They have to implement the guideline by 2010
- They have to reduce medication errors by 50% (national inspection of healthcare)



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To achieve their goals

- they can use the SOP's, starting kits, etc.
- Use an innovative method for evaluation
- Possibility for national and international pooling of data analyses
- Participate in an (inter)nationaal learning platform
- Professional supervision and training by CBO in a breakthrough project
- Funded by the ministry of healthcare
- Status of participating in an international project, publications etc.




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AUSTRALIAN COMMISSION ON SAFETY AND QUALITY IN HEALTHCARE

High 5s Project

Australian Activities

Professor Chris Baggoley
Chief Executive
Australian Commission on Safety and Quality in Health Care



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ACSQHC

The Australian Commission on Safety and Quality in Health Care

- Established by Health Ministers in 2005, commenced in 2006
- Reports to all Health Ministers
- Commissioners diversity
- Committee structure:
 - Inter-Jurisdictional Committee
 - Private Hospital Sector Committee
 - Primary Care Committee
 - Information Strategy Committee



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ACSQHC

- **Health Ministers Established ACSQHC to:**
 1. Lead and coordinate safety and quality in health care
 2. Advocate for safety and quality and report publicly
 3. Recommend national data sets
 4. Provide strategic advice to Health Ministers
 5. Recommend nationally agreed standards



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ACSQHC


- **Our Programs**
 1. Australian Charter of Healthcare Rights
 2. Open Disclosure
 3. Basic Care Issues
 - Healthcare Associated Infection
 - Patient Identification
 - Medication Safety
 - Clinical Handover
 - Recognition and Response to Clinical Deterioration
 - Falls Guidelines
 4. Tools
 - Accreditation and Credentialing
 - Information Strategy



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High 5s SOP

- Assuring medication accuracy at transitions of care
 - SOP accords with Australian practice and policy
 - Medication reconciliation has high priority
- Managing concentrated injectable medicines
- Correct procedure, correct site surgery



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Why participate?

- **Medication Program Priority**
 - o National Medication Safety and Quality
 - o Scoping Study
 - o Recommendation

1. The patient's journey through the health system

11. Promote medication reconciliation at care transition points including identifying resources (tools, models) to support implementation of medication reconciliation.



NATIONAL MEDICATION SAFETY AND QUALITY SCOPING STUDY
COMMITTEE REPORT
2009



Why participate?

Aligns with National Medicines Policy

Guiding Principle 4 Accurate medication history

An accurate and complete medication history should be obtained and documented at the time of presentation or admission, or as early as possible in the episode of care.

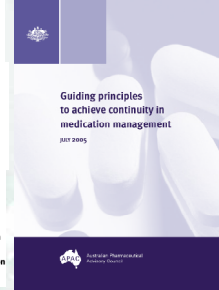
Guiding Principle 6 Medication Action Plan

A Medication Action Plan should:

- be developed with the consumer and relevant health care professionals as early as possible in the episode of care
- form an integral part of care planning for the consumer
- be reviewed during the episode of care and before transfer.

Guiding Principle 9 Communicating medicines information

When a consumer is transferred to another episode of care, the transferring health care provider(s) should supply comprehensive, complete and accurate information to the health care provider(s) responsible for continuing the consumer's medication management in accordance with their Medication Action Plan.



Preparatory work

- Engaged Commission Committees
 - Inter-Jurisdictional, Private Hospital Sector
 - Medication Chart Committee
- "Australianised" information package
- National approach to elements/format for recording medication history/reconciliation
- Prior notice of expression of interest
 - Commissions Medication Safety Bulletin
 - High 5s project page on Commission web site



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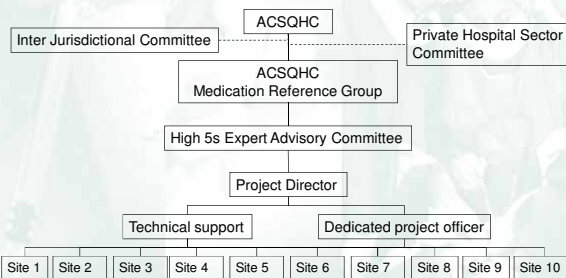
Challenges

- 5 year project
- No project money for sites
- Burden of evaluation process
 - Especially chart review for event analysis
- Limited focus – phase 1
- Geographical dispersion of sites



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Infrastructure and governance



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Status of Recruitment

• Expression of Interest (EOI) Package

- o Overview of project, SOP
 - o EOI form
 - o Distributed via
 - Inter-Jurisdictional Committee
 - Private Hospital Committee
 - ACSQHC Web site
- www.safetyandquality.gov.au
- o Closing 31 October 2009



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Status of Recruitment

- **Good level of interest**
 - - Small, large, teaching hospitals
 - - City, rural and remote hospitals
- **Hospitals selection**
 - - Across the country
 - - Public and private
 - - City, rural and remote
 - - Teaching, non teaching
- **Site selection completed**
 - - November 2009
- **Training commences**
 - - February 2010

AUSTRALIAN COMMISSION ON
SAFETY AND QUALITY IN HEALTHCARE

