PATIENT SAFETY

What is patient safety?

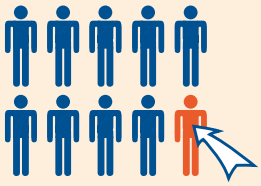
Patient safety is the foremost attribute of quality of care as defined by the **World Health Organisation**.[1]
It is defined as both:

- a goal: a state of being that is free from unnecessary harm
- a practice: processes and structures that aim to make healthcare safer

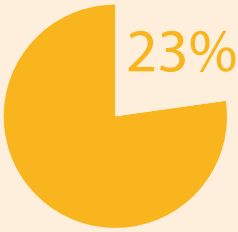
Safety covers every event that may occur in hospital settings but also in any other healthcare settings, like primary health care clinics, nursing homes, pharmacies, patients' homes and in clinical trials such as:

- harm caused as a result of a wrong diagnosis, clinical procedure or decision
- the side-effects of drugs
- hazards posed by medical devices or sub-standard products
- human shortcomings
- system errors

WHY IT MATTERS?



1 in 10 patients is harmed while receiving hospital care in developed countries, and **1.4 million people** worldwide suffer from hospital-acquired infections at any given time[2]. Data published in 2006[3] showed that:



23% **of Europeans had been directly affected by a medical error**

18% **had experienced a serious medical error in a hospital**

11% **had been prescribed the wrong medication**

Medical errors and health-care related adverse events occur in 8-12% of hospitalisations[4].

WHAT CAN BE DONE?

Patient safety culture

Adverse events in healthcare settings are often the result of a combination of system failures and human errors. Addressing safety means developing a patient safety culture by:

- ensuring that the healthcare system or organisation is aware of the potential for things to go wrong and takes measures to prevent vulnerabilities
- recognising and fully investigate errors
- taking action in order to prevent future errors

Information to patients

By becoming health literate and actively involved in managing their own condition, patients can help improve their own safety and that of others, and help make services more patient-centred. Increasing health literacy means:

- providing accessible information
- using patient-friendly language
- developing dialogue between healthcare professionals and patients

Patient involvement

Patients are a source of information about failures and gaps in the system therefore the involvement of patients, their families, and patient organisations as partners is vital. For this to become a reality, fundamental change in medical culture is necessary. Healthcare professionals and decision-makers need to:

- listen to patients
- take their concerns seriously
- accept them as equal partners
- encourage their feedback and involvement at all levels

However, involving patients should **not** mean shifting the burden of responsibility on them in an inappropriate way.

EPF ENGAGES IN PATIENT SAFETY EFFORTS AT EUROPEAN LEVEL

Patient safety is a strategic priority for EPF and goes to the heart of our work for equitable, patient-centred healthcare systems across EU. In our view, patients have a legitimate right to expect that the care they receive is safe. Increasing access to care without ensuring safety and quality of that care is meaningless.

EPF participates actively at European level debates, collaborations and projects, including the European Union Network for Patient Safety and Quality of Care (PaSQ).

PaSQ European Union Network for Patient Safety and Quality of Care

Our current focus is on patient empowerment and involvement in patient safety. Transparent, understandable and comparable information about healthcare quality is a key factor in empowering patients to make informed decisions about their care. The invaluable role of patients, families and patient organisations needs to be recognised and their participation promoted.

EPF CALLS FOR:

- EU-level guidance for the provision of meaningful information to patients on patient safety and quality of care, in collaboration with patient organisations
- Member States to involve patient organisations in patient safety strategies and actions
- Cooperation on defining common patient safety indicators for healthcare

[1] Quality of care: a process for making strategic choices in health systems. WHO, 2006. pp. 9-10. www.who.int/management/quality/assurance/QualityCare_B.Def.pdf

[2] "Ten facts about patient safety" at www.who.int

[3] Medical Errors. Special Eurobarometer, January 2006. European Commission, http://ec.europa.eu/public_opinion/archives/ebs/ebs_241_en.pdf

[4] Conklin, A. Room for improvement; Strong patient safety systems could limit health, social and economic harms from medical error. RAND Europe, 2009 http://www.rand.org/content/dam/rand/pubs/research_briefs/2009/RAND_RB9472.pdf

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EPF European Patients Forum

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