

UK Health Secretary Announces New Measures at World Patient Safety Summit



The [6th Annual World Patient Safety, Science & Technology Summit](#) kicked off with an important announcement about the progress being made to save lives in hospital settings. Nearly 4,600 hospitals in 44 countries have committed to adopting patient safety processes that are proven to eliminate preventable deaths in hospitals.

The Patient Safety Movement Foundation has taken on an inspiring and ambitious goal of reducing preventable patient deaths in hospitals to ZERO by 2020. The annual Summit in central London plays a major role in taking on that challenge with the participation of 300 global leaders, medical experts, medical technology CEOs, and patient advocates.

"If I am standing here in 2020 and we have not reached zero preventable deaths, then we at least better have implemented all of the known processes for saving lives," says Joe Kiani, Patient Safety Movement Foundation Founder and Chairman. "That we can do and we must do."

The latest advances in patient safety, called Actionable Patient Safety Solutions or (APSS), were announced today, including:

- Standardizing and Safeguarding Medication Administration
- Person and Family Engagement
- Reducing Unnecessary C-Sections
- Nasogastric Feeding and Draining Tube Placement and Verification
- Unplanned Extubation
- Early Detection & Treatment of Sepsis, for Low- and Middle-income Countries
- Air Embolism

SUMMIT KEYNOTE SPEAKER REVEALS THE TRUE COST OF MEDICATION ERRORS

Health and Social Care Secretary Jeremy Hunt launched groundbreaking new measures to improve patient safety in the National Health Service (NHS) during his keynote speech on Day One of the Summit.

The Secretary took action in response to a scathing report published on Friday, which shows the shocking toll that medication errors take on patients and the NHS system. The research – some of the first of its kind in the world– shows that errors ranging from delivering a prescription an hour late to a patient being given the wrong medication may cause approximately 1,700 deaths and are a contributing factor in 22,000 more. The NHS estimates its losses at £1.6 billion.

As a result, Secretary Hunt set out to reduce patient harm and improve safety. These measures include:

- Creating new systems linking prescribing data in primary care to hospital admissions
- Evaluate prosecutorial response only should a pharmacist make an accidental medication error due to gross negligence or malice
- Accelerating the introduction of electronic-prescribing systems across more NHS hospitals this year.

WORLD HEALTH ORGANIZATION DIRECTOR-GENERAL OUTLINES FIVE BUILDING BLOCKS OF PATIENT SAFETY

"The needless suffering of patients and their families is bad enough. But each adverse event erodes the most precious resource in health care, and that's trust. When people aren't sure whether it is safe to seek care, they will cease to seek care," said Dr. Tedros Ghebreyesus, Director-General of the World Health Organization.

No one should be harmed while seeking care. But the reality is that every year, millions of patients die or are injured because of unsafe and poor quality health care. Two-thirds of all adverse events occur in low- and middle-income countries. In his address, Dr. Tedros outlined five building

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blocks for creating a patient safety culture: strong leadership; clear policies; data-driven improvements; competent and compassionate health professionals; and people-centered care. Every instance of patient harm is a tragedy, but it is a double-tragedy if we do not learn from it and take steps to ensure the same thing never happens again.

For more information, please visit the Patient Safety Movement Foundation website.

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