World Health Organization | World Patient Safety Day 17 September 2020

World Patient Safety Day

Goals 2020–21

Health Worker Safety: A Priority for Patient Safety

The goals presented here constitute an annual call for improvement around the theme of World Patient Safety Day

World Patient Safety Day Goals

Introduction

World Patient Safety Day is observed on 17 September each year with the objectives of increasing public awareness and engagement, enhancing global understanding, and spurring global solidarity and action to promote patient safety. Each year a campaign is launched on a selected patient safety-related theme. The overall goal of World Patient Safety Day is to improve patient safety at the point of care.

To support this endeavour, World Patient Safety Day goals will be proposed from this year onwards. The goals aim to achieve tangible and measurable improvements at the point of health service delivery. Each year a set of annual goals will be proposed related to the theme of World Patient Safety Day for that year.

This document does not represent new WHO clinical or operational guidance. All of the actions in this document are based on existing World Health Organization (WHO) guidance and are summarized here for ease of reference. They are suggested for consideration and adaptation locally by teams working on patient safety and health worker safety. The process and outcome measures presented are partially derived from WHO guidance and initiatives. They are also suggested for consideration and adaptation locally but are not necessarily part of WHO core measure sets.

The World Patient Safety Day goals are addressed to health care providers and managers at the health care facility level and are formulated as the statement of best practices. Each goal is accompanied by suggested actions based on existing WHO guidance, which could facilitate improvement in the focused safety practice domain. Links to available WHO resources on the subject are provided with each goal.

Implementing and monitoring the goals

Given that health care facilities and organizations across the world have varied baselines and capacities to improve, it is not judicious to set targets from the global level. Based on where the facilities are starting their journey towards a specific goal, they can set their midterm and final targets.

Ministries of health and health care organizations are encouraged to incorporate these goals into ongoing service improvement programmes and drives. As a new set of goals will be proposed each year, implementation teams at health care facilities are advised to institutionalize patient safety improvements achieved, and to take on new goals as well as sustaining action on goals from the previous year.

WHO is setting up an online platform where health care facilities and organizations can sign up, report progress and learn from each other. A certificate of appreciation will be provided to the registered facilities.

The World Patient Safety Day goals 2020–2021 are aimed at improving health worker safety.

Let's continue the journey towards safer care!

World Patient Safety Day Goals 2020–21

Health worker safety: a priority for patient safety

Goal 1
Prevent sharps injuries

Goal 2
Reduce work-related stress and burnout

Goal 3
Improve the use of personal protective equipment

Goal 4
Promote zero tolerance of violence against health workers

Goal 5
Report and analyse serious safety-related incidents

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WPSD Goal 1

Prevent sharps injuries

1. Rationale

Sharps injuries, such as needle-stick injuries, expose health workers and patients to a number of bloodborne pathogens that can cause serious or even fatal infections. Most of these exposures in health settings are avoidable through preventive measures and new technologies. Measures taken to prevent sharps injuries amongst health workers, such as avoiding unnecessary injections and using safe injection practices, will also contribute to patient safety.

2. Links to WHO resources

- *Injection safety tools and resources page:* <more details>
- *Infection prevention and control (IPC) training package:*
  Standard precautions: injection safety. World Health Organization, United States Centers for Disease Control and Prevention, University of Washington Global Health E-Learning Program <more details>
- *WHO needle-stick injuries page:* <more details>
- *IPC core components:*
  Guidelines on core components of infection prevention and control programmes at the national and acute health care facility level. World Health Organization, 2016 <more details>
- *IPC minimum requirements:*
  Minimum requirements for infection prevention and control (IPC) programmes. World Health Organization, 2019 <more details>

3. Suggested actions

a. Elimination of threats or hazards

- Eliminate unnecessary injections:
  - Always consider if the injection is really needed.
  - Offer your patient a medication that can be taken orally or through another administration route that does not require injection, wherever appropriate.
- Maximize the use of needle-less intravenous systems.

b. Environmental and engineering controls

- Use safety-engineered devices such as needles that retract, sheathe, or break or blunt immediately after use.
- Use syringes with a reuse prevention feature.
- Use sealable, puncture-resistant, leak-proof, colour-coded sharps containers.

c. Administrative controls

- Implement policies and training programmes on how to limit exposure to hazards, for example on the use of universal precautions.
- Institute a working group focused on injection safety implementation within the facility infection prevention and control or occupational health committee.
- Implement a surveillance system for follow-up of exposed health workers, including post-exposure prophylaxis.
- Provide pre-service and ongoing immunization against hepatitis B and other vaccine-preventable diseases.

d. Work practice controls

- Place sharps containers at eye level and at arm's reach.
- Check sharps containers on a schedule and replace them before they are full.

e. Personal controls

- Avoid recapping and other hand manipulations of needles. If recapping is necessary, use a single-handed scoop technique.
- Immediately report any incident or accident linked to a needle or sharps injury and seek assistance.
- Follow the WHO recommended seven steps that make every injection safe:

  Step 1: Clean workspace.

  Step 2: Hand hygiene.

  Step 3: Sterile and new syringe and needle, with reuse prevention or injury protection feature, whenever possible.

  Step 4: Sterile vial of medication and diluent.

  Step 5: Skin disinfection.

  Step 6: Appropriate collection of sharps.

  Step 7: Appropriate waste management.

4. Barriers to implementation

- Resistance among patients and health care workers to measures aimed at decreasing injection overuse and achieving injection safety.
- Availability of necessary equipment and supplies for a transition to the exclusive use of WHO prequalified AD/RUP/SIP syringes for therapeutic injections.
- Lack of system for appropriate management of sharps waste.

5. Process and outcome measures

- Needle-stick injuries per injection provider per unit of time.
- Proportion of prescriptions including at least one injection.

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WPSD Goal 2

Reduce work-related stress and burnout

1. Rationale

Increased demand for access to health services is putting unprecedented strain on health systems and the health workforce. Many health workers are experiencing excessive work-related stress. People experiencing burnout typically feel exhaustion but are also likely to feel detached or cynical about their job. Burnout is not just linked to the health of the health workers; it also affects the safety of the patient. Burnout is also associated with increased absenteeism and staff turnover, which disrupts organizational functions, reduces team efficiency and causes a loss of institutional knowledge, leading ultimately to negative impacts on patient safety. Emergencies such as COVID-19 trigger additional stressors from long working hours with cumbersome personal protective equipment (PPE) and increased fear of contracting the infection.

2. Links to WHO resources

- *Doing what matters in times of stress:*

  Doing what matters in times of stress: an illustrated guide. World Health Organization, 2020 <more details>

- *Psychological first aid for field workers:*

  Psychological first aid: guide for field workers. World Health Organization, War Trauma Foundation, World Vision International, 2011 <more details>

- *Health workforce burnout:*

  Health workforce burnout. Bulletin of the World Health Organization, 2019;97:585–6 <more details>

- *Occupational safety and health in public health emergencies:*

  Occupational safety and health in public health emergencies: a manual for protecting health workers and responders. World Health Organization, International Labour Organization, 2018 <more details>

- *HealthWISE action manual:*

  HealthWISE – work improvement in health services – action manual. World Health Organization, International Labour Organization, 2014 <more details>

3. Suggested actions

a. Elimination of threats or hazards

- Map all psychosocial hazards and assess the associated risks that may lead to work-related stress and burnout. Prepare a risk mitigation plan to eliminate or control these hazards.
- Establish clear lines of authority and responsibility to minimize stress by eliminating confusion about who reports to whom.
- Ensure optimal layout and work processes to eliminate unnecessary movement, redundant activities and physical exertion.

b. Environmental and engineering controls

- Mitigate the effects of extreme temperatures using protective clothing, proper hydration, temperature control and frequent breaks.
- Ensure that lighting is sufficient, adjustable and in good working order.
- Promote good hygiene, cleaning, disinfection and adequate ventilation at the workplace.

c. Administrative controls

- Implement a programme to monitor and detect psychosocial risks.
- Prevent psychosocial health risks through hazard reduction and mitigative measures.
- Establish policies regarding the duration of deployments, work hours, work shift rotation and rest breaks.
- Establish channels and nodal officers for expressing and registering concerns regarding workplace safety and other inducers of stress and burnout.
- Make information available about medical, mental health and stress management services that can be provided. Share up-to-date information about workplace hazards, modes of infection transmission, symptoms and protective measures.
- Provide regular training on stress management techniques and safety policies and procedures.
- Provide psychological first aid to health workers recently exposed to extreme stress or trauma and follow up with them one to three months after the event to see if they are recovering from the event.

d. Work practice control

- Establish opportunities for physical exercise and recreation. Provide necessary facilities for rest and refreshment.
- Build a culture of open, two-way communication with staff. Give staff as much control as possible.
- Practice team-building techniques, including facilitating communication and conflict management.
- Organize periodic multidisciplinary team sessions to exchange health and safety concerns.
- Introduce the buddy system to monitor stress and burnout and provide psychological support.
- Include sufficient breaks (considering both length and frequency) according to workload and working time. Make sure that breaks are long enough to provide a sufficient period of recuperative rest.
- Rotate workers from high-stress to lower-stress functions. Redistribute workloads to avoid doing the heaviest or most difficult work at times of high fatigue, for example during the last few hours of long shifts, especially at night.
- As a rule, rotate shifts in a forward direction, not backwards (for example, day shift to afternoon shift, or evening shift to night shift).

e. Personal controls

- Maintain self-care activities such as daily exercise, good eating habits and regular sleep schedule.
- Contact and consult your occupational health focal point or a mental health professional for psychological risk assessment and counselling in case of signs of excessive stress or burnout.

4. Process and outcome measures

- Health care staff absenteeism rate.
- Health care staff turnover rate.
- Percentage of staff reporting burnout.

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WPSD Goal 3

Improve the use of personal protective equipment

1. Rationale

Personal protective equipment (PPE) provides a physical barrier between the health worker and hazardous agents. Medical non-sterile and sterile surgical gloves, medical masks, respirators, goggles or face shields, and gowns are considered as essential PPE. Personal protection in health care settings is vital both for occupational health and for infection prevention and control (IPC). Despite well defined protocols and procedures, adherence to personal protection practices has been a challenge in health care settings.

Individual, environmental and organizational factors could considerably impact PPE-related behaviours. Ensuring an adequate, continuous supply of PPE, and provision of training on its use, are both critical; however, it is equally important to institutionalize a culture of safety, including appropriate use of PPE, in particular when putting on (donning) and removing (doffing) PPE. Although the use of PPE is the most visible control used to prevent the spread of infection, it is only one of a range of IPC measures and should not be relied on as a primary prevention strategy. In the absence of effective administrative and engineering controls, PPE has limited benefit.

2. Links to WHO resources

- *Infection prevention and control (IPC) training package:*
  Transmission-based precautions. World Health Organization, United States Centers for Disease Control and Prevention, University of Washington Global Health E-Learning Program
  Standard precautions: personal protective equipment. World Health Organization, United States Centers for Disease Control and Prevention, University of Washington Global Health E-Learning Program <more details>
- *Donning and doffing PPE:*
  COVID-19: How to put on and remove personal protective equipment (PPE) (training course) <more details>
- *How to put on and take off personal protective equipment (PPE) (posters):* <more details>
- *Rational use of PPE for COVID-19:*
  Rational use of personal protective equipment for coronavirus disease (COVID-19) and considerations during severe shortages: interim guidance. World Health Organization, 2020 <more details>
- *PPE for use in a filovirus disease outbreak:*
  Personal protective equipment for use in a filovirus disease outbreak: rapid advice guideline. World Health Organization, 2016 <more details>

3. Suggested actions

a. Minimize the need for PPE

- Use physical barriers such as glass or plastic windows to reduce exposure to infectious agents. This approach can be implemented in areas of the health care setting where patients will first present, such as triage areas, the registration desk at the emergency department, or at the pharmacy window where medication is collected.
- Consider bundling activities to minimize the number of times a room is entered (for example, check vital signs during medication administration or have food delivered by health workers while they are performing other duties), and plan which activities will be performed at the bedside.
- Consider using specific PPE only if in direct or close contact with the patient or when touching the environment (for example, wearing a medical mask and face shield, not using gloves or gown over the scrub suit, if entering the patient's room only to ask questions or make visual checks).

b. Environmental and engineering controls

- Ensure adequate supplies of water services and products for hand hygiene, cleaning and disinfection.
- Implement adequate management of reusable and disposable PPE items.
- Provide dedicated spaces for putting on and removing PPE to prevent any cross-contamination.
- Make available cooling and rehydrating facilities for use by health workers taking off PPE.
- Ensure that cleaning and disinfection procedures are followed consistently and correctly and performed frequently.
- Ensure that heating, ventilation and air-conditioning systems (where applicable) are appropriately managed and regularly cleaned.

c. Administrative controls

- Conduct risk assessments for specific tasks in order to select the most appropriate PPE for them. Selection factors include supply, size, fit, protection level, comfort, design and experience in use.
- Provide mandatory training on policies and procedures regarding the use of all PPE, including donning and doffing, and disposal or storage.
- Implement frequent supportive supervision and feedback mechanisms. Periodic assessment should be carried out of proficiency and competence in using PPE.
- Implement protocols for reporting a breach in PPE materials or use.
- Establish stock management, including a locally held buffer stock, to make sure that different sizes and recommended shapes of PPE are available. Set up a system to prevent or ensure early reporting of shortages, including maintaining a locally held buffer stock.
- Make PPE easily accessible through an optimal placement system to avoid staff having to search for replacement PPE.
- Control the quality of PPE purchased. Follow national and international standards for procuring reliable products.
- Implement policies on the rational use of available supplies of PPE in the context of critical shortages.

d. Work practice controls

- Put on PPE correctly before entry into the patient care area. PPE should not be modified while in the patient care area.
- Safely manage used and potentially contaminated PPE, including through application of safe discarding or reprocessing procedures.
- Establish a buddy system, partnering for assistance and review, for putting on, use and removal to increase the safe use of PPE. Remove PPE under the guidance and supervision of a trained observer (colleague).
- Use PPE in the context of other prevention and control strategies and in accordance with IPC recommendations (including standard, contact, droplet and airborne precautions).
- Base glove selection on the task to be performed. Use of sterile gloves is indicated only when an invasive procedure involving mucous membranes or blood is involved.
- Avoid any contact between contaminated (used) PPE and surfaces, clothing or people outside the patient care area.
- Ensure that infectious waste containers are available in the removal area for safe disposal of PPE. Separate containers should be available for reusable items.
- Discard the used PPE in appropriate disposal bags and dispose of as per the established policy.

e. Personal controls

- Frequently perform hand hygiene while putting on and removing PPE as per protocols.
- Ensure that health workers undergo practical training on safe techniques for putting on and removing PPE.
- Discard the used PPE as per established protocols.
- Report any breach of or non-adherence to personal protection practices.
- Do not share PPE.

4. Barriers to implementation

- Perception issues: using PPE interferes with the health care worker's ability to perform his or her job, and can be perceived as overly time consuming and ineffective.
- Access issues: supply shortages and lack of access to PPE.
- Lack of emphasis on safety culture in the organization.

5. Process and outcome measures

- Number of PPE stockouts per unit of time.
- Number of PPE breaches reported per unit of time.

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WPSD Goal 4

Promote zero tolerance of violence against health workers

1. Rationale

Health workers are at high risk of violence all over the world. They are also threatened or exposed to verbal aggression. In disaster and conflict situations, health workers may become the targets of collective or political violence. In the case of infectious diseases, there may be doubts about the existence of the disease agent, prompting some people to question the intentions of health workers. Mistrust can turn to hostility and violence, which can be directed at health workers and others dealing directly with patients and their families.

Categories of health workers most at risk include nurses and other staff directly involved in patient care, emergency room staff and paramedics.

Violence against health workers not only has a negative impact on the psychological and physical well-being of health care staff but also affects their job motivation. Consequently, violence in health care facilities also compromises the safety of patients.

2. Links to WHO resources

- *Attacks on health care initiative:*
  Stopping attacks on health care. Attacks on health care initiative: Prevent. Protect. Provide <more details>
- *Violence and injury prevention:*
  Framework guidelines for addressing workplace violence in the health sector. Joint Programme on Workplace Violence in the Health Sector. World Health Organization, 2002 <more details>

3. Suggested actions

a. Elimination of threats or hazards

- Conduct a facility security review and provide on-site security services according to the assessed risk.
- Checking for weapons should be considered with great caution and implemented if necessary, according to local law and practice, with the main aim of avoiding any unnecessary risk.
- Regulate public access to the main health care facility according to agreed protocols.
- Restrict access to staff areas (for example, changing rooms, rest areas) to authorized personnel of the facility.
- Maintain links with the local police to acquire up-to-date information on problem locations or known violent patients or family members.

b. Environmental and engineering controls

- Maintain good illumination to improve visibility in all areas, particularly access, parking and store areas, especially at night.
- Take measures to provide adequate temperature, humidity and ventilation, especially in crowded areas and in hot climates.
- Arrange furniture in such a way as to prevent entrapment of staff. In interview rooms or crisis treatment areas, furniture should be minimal, lightweight, without sharp corners or edges, and, where appropriate, affixed to the floor.
- Provide treatment rooms with two exits or, where this is not possible, arrange them in a manner that allows easy means of exit.
- Carry out security screening of visitors prior to their entering the facilities. Surveillance cameras should be installed in potentially dangerous areas.
- Provide alarm systems (such as telephone, beeper or short-wave radio) to workers where risk is apparent or may be anticipated to enable them to alert or notify other colleagues.
- Use protective barriers for workers at special risk and to separate dangerous patients from other patients and the public.
- Provide comfortable seating arrangements, especially where long waiting is involved. Boredom can be reduced by providing activities (such as reading materials, television, toys for children).

c. Administrative controls

- Organize rapid response teams and emergency activation systems to respond to situations in which staff and patient security is at risk.
- Recognize overall responsibility for ensuring the health, safety and well-being of workers, including elimination of the predictable risk of workplace violence, according to national legislation and practice.
- Conduct routine assessment of incidents of workplace violence and the factors that lead to or generate workplace violence.
- Develop policies and plans at the workplace to combat workplace violence and establish the required monitoring mechanisms and range of actions.
- Regularly consult with workers and their representatives to find out if violence and harassment are occurring or if there are any factors likely to increase the risk.
- Compile, distribute, display and apply codes of conduct, explaining the obligations as well as the rights of patients, relatives and friends. Explicitly display caution, stating that no violent behaviour or behaviour intentionally generating violence will be tolerated.
- Report and record all incidents involving either physical or psychological violence, as well as minor and potential incidents where no actual harm resulted. A periodic review should be undertaken of such reports of incidents as an indicator for improving workplace safety measures.

4. Process and outcome measures

- Number of potentially violent incidents prevented per unit of time (near misses).
- Number of violent incidents committed against health workers per unit of time.
- Number of full-time equivalent workdays lost due to violent incidents.

d. Work practice controls

- Provide workers with clear instructions and training on how to effectively defuse hostile situations involving patients, families and members of the general public to whom they provide a service.
- Involve community leaders, wherever possible, as they can reassure communities and help in diffusing potentially violent situations.
- Arrange duty rosters so that workers in risky situations do not work alone, and help staff to be swiftly alerted and aid provided in case of violent situations.
- Tailor client flow and the scheduling of appointments to suit needs and resources. Waiting times should be kept to a minimum, and crowding should be avoided.
- Ensure that night shift workers, especially women and those moving from building to building or working in isolated areas of a building, work together or in close proximity to each other. Transportation should be provided to night shift workers.
- Respect the privacy of patients to the extent possible.

e. Personal controls

- Establish a good rapport with patients' or victims' families. Keep them up to date regarding waiting times and reasonable expectations. This helps prevent any misinterpretation and hostility.
- Show respect for tradition without compromising safety. Traditional customs and practices should be encouraged as long as they can be carried out safely.
- Escalate any violent or potentially violent behaviour to administration or to the occupational safety focal point, as per defined procedures.
- Seek guidance and counselling if involved in situations that may lead to workplace violence.
- Maintain physical fitness and a stable emotional state as an effective means of coping with workplace violence.

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Report and analyse serious safety-related incidents

WPSD Goal 5

1. Rationale

Serious patient safety and occupational safety incidents[1] provide critical insight into the level of safety in health care facilities. Emergencies such as COVID-19 pose multiple threats to health workers, including threat of fatality. It is essential to measure, analyse and learn from serious patient safety and health worker safety incidents. Data on safety-related incidents could also be used by governments, researchers and global development agencies to design better policies, procedures and practices for safer health care delivery systems. Periodic review of cumulative safety incident data can provide an understanding of how patient safety and occupation safety programmes are progressing.

2. Links to WHO resources

- *Assessing and tackling patient harm:*
  Assessing and tackling patient harm: a methodological guide for data-poor hospitals. World Health Organization, 2010 <more details>
- *Conceptual Framework for the International Classification for Patient Safety:*
  Conceptual Framework for the International Classification for Patient Safety, version 1.1. Final technical report, January 2009. World Health Organization, WHO Patient Safety, 2009 <more details>
- *Patient safety incident reporting:*
  Patient safety incident reporting and learning systems: technical report and guidance. World Health Organization; 2020 <more details>

3. Suggested actions

a. Minimising the barriers to report

- Replace paper forms with electronic methods of reporting wherever feasible.
- Remove the fear of blame and retribution from the culture of reporting. The organization should make a formal commitment to eliminate blame culture and encourage blame-free reporting.

b. Environmental and engineering controls

- Establish a telephone hotline (appropriately staffed, skilled, and with rigorous governance arrangements) for staff to report serious incidents that require escalation and immediate action to protect other patients and health workers from harm.
- Implement a coding system based on ICD-11[2] to assist in accurately capturing data on safety in health care.

c. Administrative controls

- Create a positive environment for reporting through the commitment of clinical and managerial leaders.
- Establish and operationalize a patient safety incident reporting system based on the *Patient safety incident reporting and learning systems* guidance developed by WHO.
- Publish and communicate clear guidance and definitions for staff on what should be reported and what mechanisms should be used to make a report.
- Establish a policy for reporting serious incidents such as never events[3] and sentinel events[4] in health care facilities. Define such incidents and communicate policies across the organization.
- Make mandatory immediate reporting and investigation of serious safety-related incidents.
- Establish safety incident review committees and standard operating procedures aligned with clinical governance structures in the organization.
- Give staff regular feedback on progress with the investigation of the incident that they reported and what action was taken on this matter.

d. Work practice controls

- Ensure periodic review of all serious safety-related incident reported in health care facilities.
- Perform in-depth systemic analysis to identify the causal and contributory factors for suspected serious safety-related incidents. Plan and take corrective actions on identified causal factors.
- Calculate and report risk-adjusted mortality rates and cause-specific mortality rates. Regularly monitor the trends.
- Report occupational safety incidents at health care facilities to the designated national or subnational occupational health agency or labour office.

e. Personal controls

- Train all patient care staff on never event and sentinel event policies and impart hands-on skills for using patient safety incident reporting and learning systems.

4. Barriers to implementation

- Opaque and hierarchical organizational culture.
- Lack of leadership commitment and support.
- Fear of punitive action and performance devaluation on reporting of safety incidents.
- Non-availability of policy, procedures and equipment for reporting patient safety incidents.
- Lack of capacity for analysing and taking corrective action on patient safety incidents.

5. Process and outcome measures

- Number and proportion of serious safety-related incidents reported in a health care facility in a given time period.
- Number of safety incident review committee meetings organized annually.
- Percentage of incidents reviewed where corrective action was taken.

1. *A "serious" incident is "an event that results in death or loss of a body part or disability or loss of bodily function lasting more than seven days or still present at the time of discharge from an inpatient health care facility or, when referring to other than an adverse event, an event whose occurrence is grave" (The Conceptual Framework for the International Classification for Patient Safety, version 1.1. Technical annex 2: Glossary of patient safety concepts and references. Geneva: World Health Organization; 2009).*
2. *ICD-11. International Classification of Diseases 11th Revision. Geneva: World Health Organization; 2018.*
3. *Never event: "Patient safety incident that result in serious patient harm or death" (Never events for hospital care in Canada. Edmonton: Canadian Patient Safety Institute; 2015).*
4. *Sentinel event: "An unexpected occurrence involving death or serious physical or psychological injury, or the risk thereof. Serious injury specifically includes loss of limb or function. The phrase* or risk thereof *includes any process variation for which a recurrence would carry a significant chance of a serious adverse outcome" (The Conceptual Framework for the International Classification for Patient Safety, version 1.1. Technical annex 2: Glossary of patient safety concepts and references. Geneva: World Health Organization; 2009).*

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