

Text

Recommendation Rec(2006)7 Council of Europe, Committee of Ministers

Recommends that governments of member states, according to their competencies:

- i. ensure that patient safety is the cornerstone of all relevant health policies, in particular policies to improve quality;
- ii. develop a coherent and comprehensive patient-safety policy framework which:
 - a. promotes a culture of safety at all levels of health care;
 - b. takes a proactive and preventive approach in designing health systems for patient safety;
 - c. makes patient safety a leadership and management priority;
 - d. emphasises the importance of learning from patient-safety incidents;
- iii. promote the development of a reporting system for patient-safety incidents in order to enhance patient safety by learning from such incidents; this system should:
 - a. be non-punitive and fair in purpose;
 - b. be independent of other regulatory processes;
 - c. be designed in such a way as to encourage health-care providers and health-care personnel to report safety incidents (for instance, wherever possible, reporting should be voluntary, anonymous and confidential);
 - d. set out a system for collecting and analysing reports of adverse events locally and, when the need arises, aggregated at a regional or national level, with the aim of improving patient safety; for this purpose, resources must be specifically allocated;
 - e. involve both private and public sectors;
 - f. facilitate the involvement of patients, their relatives and all other informal caregivers in all aspects of activities relating to patient safety, including reporting of patient-safety incidents;
- iv. review the role of other existing data sources, such as patient complaints and compensation systems, clinical databases and monitoring systems as a complementary source of information on patient safety;
- v. promote the development of educational programmes for all relevant health-care personnel, including managers, to improve the understanding of clinical decision making, safety, risk management and appropriate approaches in the case of a patient-safety incident;
- vi. develop reliable and valid indicators of patient safety for various health-care settings that can be used to identify safety problems, evaluate the effectiveness of interventions aimed at improving safety, and facilitate international comparisons;
- vii. co-operate internationally to build a platform for the mutual exchange of experience and knowledge of all aspects of health-care safety, including:
 - a. the proactive design of safe health-care systems;
 - b. the reporting of patient-safety incidents, and learning from the incidents and from the reporting;
 - c. methods to standardise health-care processes;

- d.* methods of risk identification and management;
 - e.* the development of standardised patient-safety indicators;
 - f.* the development of a standard nomenclature/taxonomy for patient safety and safety of care processes;
 - g.* methods of involving patients and caregivers in order to improve safety;
 - h.* the content of training programmes and methods to implement a safety culture to influence people's attitudes (both patients and personnel);
- viii. promote research on patient safety;
 - ix. produce regular reports on actions taken nationally to improve patient safety;
 - x. to this end, whenever feasible, carry out the measures presented in the appendix to this recommendation;
 - xi. translate this document and develop adequate local implementation strategies; health-care organisations, professional bodies and educational institutions should be made aware of the existence of this recommendation and be encouraged to follow the methods suggested so that the key elements can be put into everyday practice.