Editorial

The Council of Europe recommendation Rec(2006)7 on management of patient safety and prevention of adverse events in health care

Among the various national and international initiatives to promote patient safety that have emerged in recent years, one has remained confidential, almost invisible—the Council of Europe Recommendation Rec(2006)7 of the Committee of Ministers to member states on the management of patient safety and prevention of adverse events in health care [1]. I believe that this is unfortunate, as this recommendation may stimulate progress in patient safety, but only if ‘member states’ are listening. The aim of this editorial is to get the readers of the journal to read, critique and discuss this document—better yet, to use it.

The recommendation outlines a comprehensive policy to improve patient safety, intended for implementation at the national level, but with a clear intent to foster international collaboration in this area. Although it is not a legally binding document, it has been approved by the Committee of ministers of the Council of Europe in May 2006, and as such is supposed to guide policy in the 47 member states of the Council, from Russia to Malta and from Azerbaijan to Iceland (in addition, Israel, Canada, Mexico, Japan, the USA and the Holy See have observer status with the Council). Note that the Council of Europe has lent its flag to Iceland (in addition, Israel, Canada, Mexico, Japan, the USA and the Holy See have observer status with the Council). As the Council is concerned with the governance of nations whose health-care systems differ enormously in their stage of development, their philosophy and in the amount of resources available, its recommendations have potential applicability worldwide. Furthermore, the ministers who approve the recommendations of the Council are not health ministers, but ministers of foreign affairs. As such, they are not suspect of lobbying for their own health-care related portfolios, which lends further credibility to the recommendation.

The recommendation provides useful arguments to anyone who deals with possibly reluctant public authorities and tries to convince them of the importance of patient safety (Box 1). This document is based on work done between 2003 and 2004 by a Committee of experts (disclaimer: of which I was a member) designated by the Council and presided by Dr Pirjo Pennanen of Finland. Although the initial mandate emphasized the role of reporting systems for health-care incidents, the need for a more global policy became rapidly obvious. Thus, the recommendation places concern for patient safety at the core of quality improvement policies (Box 1, (i)) and spells out the need for a comprehensive framework that recognizes the key role of leadership and that values a just safety culture, the importance of prevention, and continuous learning (Box 1, (ii)). The reporting system for patient-safety incidents still figures prominently (Box 1, (iii)) but the use of other sources of information (Box 1, (iv)) and the development of valid safety indicators (Box 1, (v)) are given due recognition. The recommendation also puts academic institutions to task by requesting training for patient safety for all categories of health-care personnel (Box 1, (vi)) and research into patient safety (Box 1, (vii)). The recommendation is accompanied by an extensive Appendix which provides a technical and scientific background and justification to the recommendation.

The recommendation puts a strong emphasis on international collaboration (Box 1, (vii)). Some key topics, such as the need to develop a common taxonomy, or classification, for patient safety, and the utility to involve patients in safety management, appear only as areas for international collaboration. The recommendation does not say what body should be responsible for these international endeavours, but the World Alliance for Patient Safety has clearly taken on much of this work [2]. This does not mean that other international bodies, including the International Society for Quality in Health Care, should not also play a role.

Nothing in the recommendation is terribly original. Many of these topics figure prominently in the Programme of the World Alliance for Patient Safety [2], including the need for professional education in patient safety, the involvement of patients, the need for an international classification [3] and applied research. Incidentally, my earlier editorial about research on patient safety was partly based on the then unpublished Council of Europe work [4]. However, unlike other position papers, the recommendation bears an official seal of approval—that of foreign ministers of dozens of countries representing hundreds of millions of inhabitants.

Even good recommendations are ineffective if nobody knows about them. The intended recipients of the document are the governments of the member states, but counting on


Box 1 Recommendation Rec(2006)7 of the Committee of Ministers to member states on management of patient safety and prevention of adverse events in health care

The Committee of Ministers, under the terms of Article 15.b of the Statute of the Council of Europe, [...] 

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) emphasizes 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 standardize health-care processes;
   (d) methods of risk identification and management;
   (e) the development of standardized 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 organizations, 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.

bureaucracies may not be the most effective implementation strategy. The Committee of Ministers seems to be aware of this, since it concludes with this call—’health-care organizations, professional bodies and educational institutions should be made aware of the existence of this recommendation and be encouraged to follow the methods suggested.’ You, reader, are probably among the intended recipients.

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References


