EU Validation of a Minimal Information Model for Patient Safety Incident Reporting and Learning Systems

EXECUTIVE SUMMARY

World Health Organization

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Introduction

Patient safety has risen to the frontline of quality management as one of the most vital and strategic topics in health care. The increasing incidence and impact of risks generated by complex health service delivery systems, and continuously emerging technologies, on the patient and the health care professional, have been widely documented. Hence the actions taken at global, regional, national and institutional levels to address safety cultures, and regulate and implement robust reporting and learning systems to improve patient safety.

The restricted ability of established reporting systems to inter-operate and exchange safety-relevant information represents one of the major challenges faced in the development of risk reduction interventions. The reasons for this are manifold and include the lack of an accepted taxonomy and the scarcity of universally applicable standards for collecting, classifying, analyzing and interpreting incident reports.

The European validation of the minimal information model for patient safety (MIM PS) incident reporting and learning project started in December 2013 as a country-driven collaborative undertaking. Within this project, the World Health Organization (WHO) is supporting the European Commission and the EU Member States to advance the development of a common MIM PS, to facilitate comparison, sharing and global learning from the occurrence of patient safety incidents, as they are recorded in reporting systems.

> "The primary purpose of a patient safety reporting system is to learn from experience. A reporting system must produce a visible, useful response to justify the resources expended and to stimulate reporting. The most important function of a reporting system is to use the results of data analysis and investigation to formulate and disseminate recommendations for systems change."
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> WHO Draft Guidelines for Adverse Event Reporting and Learning Systems, 2005

The MIM PS validation process in EU Member States builds on the experience of the European Union Network for Patient Safety and Quality of Care (PaSQ Joint Action) and of the EU Patient Safety and Quality of Care Expert Group managed by the European Commission's Health and Food Safety Directorate General (DG SANTE) and its Reporting & Learning subgroup in particular, which was involved in mapping existing practices of incident reporting across the EU, and drawing a set of preferred terms for incident reporting.

Drawing from previous work, international experience and in collaboration with partners, WHO and the European Commission worked together with EU Member States to advance the development of the Minimal Information Model for Patient Safety (MIM PS) reporting and learning systems. The goal of the MIM PS is to be used as a common template by healthcare institutions so that data collection, review, comparison and analysis of incident reports can be performed across institutional borders, and enhance learning practices and safety knowledge. This model will also be a useful template to organize new reporting systems in countries with insufficient development in this field, and further advance the patient safety agenda.

History of the Minimal Information Model for Patient Safety Incident Reporting and Learning Systems (MIM PS)

WHO has been leading work to accelerate and expand patient safety improvements since the launch of its dedicated programme in 2004. The "Draft Guidelines for Adverse Event Reporting and Learning Systems" [1]