

LE LIEN and WHO, together for patient safety

Paris, 25 November 2014, LE LIEN in collaboration with the World Health Organisation:

The LE LIEN association, in collaboration with WHO, organised a joint colloquium at the National Assembly in the context of the 4th edition of patient safety week, bringing together representatives of users, healthcare professionals, institutional representatives and public healthcare decision-makers. On this occasion, WHO presented its programme on involvement of patients and families in patient safety for the first time in France. For WHO, the issue is to encourage involvement of patients and their families at the global level to improve the safety and quality of care. For this first presentation, in France, WHO has chosen to rely on LE LIEN, whose involvement and audience in this area it has been able to gauge.

LE LIEN can of course identify with and support this initiative, inasmuch as it corresponds exactly to its own commitments for almost two decades.

Opening of the colloquium

Mr Alain-Michel Céretti, Founder of LE LIEN



Mr Alain-Michel Céretti thanks the representatives of WHO for having chosen LE LIEN to co-organise this colloquium in Paris and in the premises of the National Assembly. He also thanks Mr Hervé Féron, Deputy from Meurthe-et-Moselle, for hosting them in this prestigious location.

The day's objective is to discover the programme "*Patients for Patient Safety*" that WHO is developing internationally to promote patient safety and those who deal with it, and beyond this, to consider the way France is working on the subject with elected officials, institutions and non-profit organisations.

Mr Alain-Michel Céretti gives the floor to Mr Hervé Féron.

Introductory address Mr Hervé Féron, Deputy from Meurthe-et-Moselle



*“Thank you Mr
Céretti, ladies and
gentlemen,*

I am truly honoured today to introduce this colloquium that brings together, across borders, eminent specialists in the healthcare field. The fact that we are gathered here proves that we are all aware of one thing: while health is already everyone’s business, the issue of patient safety must be also.

I would like to stress the remarkable work done by the members of Le Lien, this association that has been committed for almost two decades to improvement in the safety and quality of care. We have had cordial and fruitful exchanges in the course of these last few months with Ms RICHON and Mr CERETTI, and I thank them sincerely for having, with the World Health Organisation, initiated this colloquium which I hope will give rise to the foundation of an international collaboration on this subject, to which we have been committed for a number of years.

Each year, hundreds of thousands of people around the world suffer injury and sometimes even die for reasons related to medical care. In France alone, 4500 people die of this each year, or as many as in road accidents.

It seems absurd to think that a person could leave the hospital in worse health than when he entered it. Unfortunately this is often the case. In France, 7% of hospitalisations are complicated by a nosocomial infection, or approximately 750,000 cases of the fifteen million hospitalisations annually.

The result is a human cost, of course, but also a financial cost for our social security systems. Nosocomial infections generate an annual added cost estimated at between 2.4 and 6 billion euro for our country. Moreover, the well-known existence of risks in the hospital environment adds to the fear of patients and their families with regard to the healthcare services. This situation contributes to a decrease in trust in healthcare personnel and professionals, but also in the national institutions, of which I am now one of the representatives.

With this in mind, the quality of care and patient safety must constitute a public health priority, and we must equip ourselves with effective means to control nosocomial infections. This was the essence of the reply that the Minister of Health made to me in the Assembly in 2013, when I asked her more specifically about the use of antibacterial copper.

I would like to draw your attention to this point, in light of the special interest of copper contact surfaces or alloys with regard to antibacterial activity.

Numerous scientific studies have been conducted on the subject, proving in particular that 99% of the bacteria principally responsible for nosocomial infections, even those highly resistant to antibiotics, die in less than two hours in contact with a copper surface.

Moreover, use of copper would allow the incidence of nosocomial infections to be reduced by more than 40%, as Professor Michael Schmidt of the Medical University of South Carolina has shown.

In situ experiments conducted throughout the world have confirmed these scientific data. In France, the Hospital Centres of Rambouillet and Amiens have equipped themselves with copper fittings. The recently disclosed results of this trial leave no room for doubt. Copper has significantly reduced the presence of bacteria in the neonatal unit of the Amiens UHC, while at Rambouillet, the acquisition rate of multi-resistant bacteria by patients in the intensive care unit dropped throughout the entire trial. In this same dynamic, five EHPADs [nursing homes] in Champagne-Ardenne have announced their intention to equip themselves with copper this year, kicking off the largest trial conducted to date on copper in a healthcare establishment.

We will have the opportunity to go further into the subject of antibacterial copper during the discussion on healthcare safety that will be held at 2 p.m. As unfortunately I cannot be with you at that time, I have asked my colleague to send me all the information, which will definitely interest me, on this subject that is of special importance to me.

In fact I have appealed to the Ministry of Health several times. I have in particular suggested equipping the units of ten French hospitals especially subject to nosocomial infections with copper fittings and to conduct a trial over three years, accompanied by an evaluation of the results obtained in terms of effect on public health but also on healthcare economics. Very recently I wished to discuss with the Minister the urgent necessity of acknowledging the efficacy of antibacterial copper against nosocomial illnesses, believing that the Public Health Bill presented 16 October in the Council of Ministers would represent a perfect opportunity.

*To take advantage of this essential healthcare tool, I am convinced that hospital managements, technical institutes and political leaders share a great responsibility.
We cannot dispense with innovation in the field of patient safety and health in general.*

I share with you the hope that our message is heard by the highest national authorities, so that ultimately every member of the public can benefit from the best possible protection against nosocomial illnesses.

Allow me to tell you an anecdote. At the National Assembly, in the lower chamber, the deputies speak in turn into a pink-coloured microphone which is unmistakably of copper. Why, as a deputy, should I speak into a copper microphone protecting me from any risk of contagion while the majority of people are exposed to this risk?

To conclude, I would like to read to you these few words that were sent to me by the Minister of Health. As she was unable to get away, she wanted in this way to demonstrate her interest in our initiative.”

Message from the Minister

Ms Marisol Touraine, Minister of Social Affairs, Health and Women's Rights

*“To the Deputy, dear Hervé Féron,
the President of LE LIEN,
Members of the Board of Directors, ladies and gentlemen,
Dear Claude Rambaud, whose historic involvement in Le Lien I know and whom I am happy to greet.*

I regret that I am unable to be among you, but I would like to address this message to you. Allow me first of all to stress the commitment of the LE LIEN association, an association for the defence of patients and healthcare users. I know that it has worked for years, with conviction and efficacy, to defend victims of medical accidents and in particular victims of nosocomial infections. It represents them before the various healthcare institutions and administrative authorities to promote healthcare safety and the quality of treatment.

I am pleased by the presence among you of representatives of the World Health Organisation. WHO has made patient safety one of its priorities with the campaigns on hand hygiene and operating theatre safety. Finally, WHO is taking action on the major global challenge of antibiotic resistance.

For years France has been heavily involved in these activities (control of nosocomial infections, combating iatrogenesis, promotion of the proper use of medications, etc.).

Health security and the quality of care are priorities for me. They are strategic areas of focus to which my Ministry is totally committed. My main concern is that the patient be the main participant in his course of treatment. All healthcare professionals must coordinate around the needs of the patient and guarantee the quality and safety of his care. If adverse events related to care occur, they must be identified rapidly, managed efficiently and better prevented in the future.

This aim requires involving all those involved in health: professionals, patients, and associations and elected officials. Professionals must be constantly better trained and informed on healthcare safety. Finally, we must support research and innovation. These are the aims of the National Patient Safety Programme.

As you know, the 2009-2013 national programme for prevention of nosocomial infections ended in December 2013 and was evaluated by the Haut Conseil en Santé Publique [High Council for Public Health] in 2014. With a view toward development of the new programme, I will support emphases taking into account the patient's overall course of treatment and involving healthcare establishments, medico-social establishments and general practitioners.

The group steered by Professor Brun-Buisson has proposed major areas of emphasis:

- *To develop prevention of healthcare-related acquired infections throughout the course of treatment by involving patients and residents of establishments.*
- *To step up prevention and control of antibiotic resistance in all sectors of the healthcare offering; this is a national priority.*
- *To reduce the infectious risks associated with invasive procedures.*

This new programme is not yet finalised; it will reach its final form by the end of the year. We hope that it will be ongoing and that professionals in the three sectors covered (healthcare, outpatient and medico-social) support it. I would also like coordination of the programmes and existing plans: a national programme for prevention of infections, a national plan for antibiotic alerts and a national patient safety programme.

The national health strategy gives us a framework for action in the years to come. I announced in the healthcare bill a reform of the agencies, with the creation of a major public health institute with a comprehensive approach to issues of monitoring and prevention in healthcare. In addition we are going to reorganise the vigilance system, relying on the recommendations of the reports of Jean Yves Grall.

These provisions, which I will defend before the parliament soon, will further increase healthcare safety and promote everyone's safety and the quality of care. I know that you care deeply about this, as do I.

I wish you fruitful discussions.

I thank you for your attention and wish you an excellent colloquium."

Opening of the session

Ms Béatrice Céretti, President of LE LIEN



Ms Béatrice Céretti reviews the history of the creation of Le Lien in 1997, at the time the only association devoted to supporting patients who, like her, were victims of a nosocomial infection during their stay at the Clinique du Sport.

Today, LE LIEN is a national and international standard with regard to healthcare safety. She recalls that after the association was created, highly involved people joined her with the objective of preventing medical accidents.

Ms Béatrice Céretti is delighted that WHO is unveiling its healthcare safety programme for the first time in France, and relying on LE LIEN in doing so. This is a matter of leading patients in taking action at the global level.

1st roundtable

Objectives of the seminar and presentation of the participants

Ms Laetitia May-Michelangeli, Department Head, Patient Safety Mission, HAS

Mr Michel Dumont, President of the Antimicrobial Cluster of Champagne-Ardenne

Mr Jean Carlet, President of AC2BMR

Ms Anne-Gaëlle Venier, Reporting Manager, CCLIN [Coordination Centre for Controlling Nosocomial Infections], Southwest UHC of Bordeaux

Three questions:

What brings us together?

What are our motivations?

What can each of us contribute?



Dr Laetitia May-Michelangeli recalls that she made the acquaintance of Le Lien as a medical health officer in the context of the first conference of Le Lien, the objective of which was control of nosocomial infections. After taking on responsibilities at the Directorate General of Healthcare, she has since 2013 acted as Department Head of the Patient Safety Mission at the Haute Autorité de Santé (HAS) [*National Authority for Health*]. She notes that the role of the association is becoming more and more important in proportion to the recognition granted by the State. Avoiding risks, improving the quality of care and patient safety, and acting for and with the patient are part of what has always motivated her.

Dr Laetitia May-Michelangeli is now taking part on behalf of the HAS in the 2014-2017 National Patient Safety Programme, one of the emphases of which is devoted to patients. One of the issues in patient safety is that the patient should become a participant in his safety. The HAS has initiated a number of activities along these lines and takes into account numerous parameters in the treatment of patients. She stresses that at the HAS “expert status” has been granted to patients and their representatives.

It seems essential that LE LIEN support these initiatives and participate in them. Patient Safety Week, which began on the very eve of this colloquium, is an example of this.

LE LIEN can of course identify with and support these initiatives, inasmuch as the association has had its own commitments for two decades. This is a genuine recognition for the association. This day spent together should allow further development of methods for action.

Mr Alain-Michel Céretti stresses the importance that must be attached to motivation and effective collaboration of all those involved.

He gives the floor to Mr Michel Dumont, promoter of the perfect example of a collaborative initiative.



Mr Michel Dumont, President of the Le Bronze Alloys group, recalls the 2011 Conference of Le Lien. It was on this occasion that his attention was caught by a presentation on the ability of copper to kill bacteria.

This led him to set up an “antimicrobial cluster” involving various companies in Champagne-Ardenne. The fundamental idea was to consider the use of copper and also silver for their recognised antibacterial properties, with machining and trial of dry contact surfaces like door handles, among other things, frequently handled in healthcare establishments.

An entire movement was thus created around this cluster.

Conducting scientific studies of the bactericidal behaviour of several copper alloys manufactured by his group, he then developed a trial with patients in five EHPADs in Champagne-Ardenne.

For three years, this trial will have the aim of verifying the possibility of a conclusive reduction in the progression of illnesses and epidemics in the EHPAD using these means.

Mr Michel Dumont stresses that this initiative constitutes one of the largest experimental sites worldwide in this field.

He notes that, since the presentation of the results of the trial conducted at the Rambouillet hospital, an acceleration and intensification of manifestations of interest has been noted by professionals as well as public decision makers.

This is a social responsibility, a public involvement to which an innovative business is joined, and in particular its Research & Development department.

Mr Alain-Michel Céretti welcomes this example of public involvement that is not limited to personal commitment, but involves businesses. This is obviously essential if one wants to end up with operational applications, whether medical devices or medications for patients are involved.

He gives the floor to Dr Jean Carlet.



Dr Jean Carlet recalls his initial experience as a critical care physician, which led him to take on responsibilities thereafter in improvement of the quality of care and to take part in WHO projects and evaluate their efficacy.

Resistance to antibiotics has become a major public health issue. Bacteria have now become resistant to broad-spectrum antibiotics.

This resistance phenomenon is beginning to appear in general practice.

We are now confronted with resistances likely to involve all antibiotics. There is a real threat of multi-resistance.

This phenomenon is of course correlated with consumption of antibiotics, of which we remain among the greatest consumers. The ICATB indicator of proper use is valuable in this regard.

And it should be noted that this overconsumption also affects animals.

We therefore have to confront a problem that is subject to increased awareness worldwide.

Initiatives have arisen in recent years.

Dr Jean Carlet reports the creation three years ago of an alliance in the form of an association in order to develop the most effective responses possible. This is AC2BMR, the only association established in France to date to control antibiotic resistance. This problem is compared to global warming, and leaders like Barack Obama and the Prime Minister of Great Britain have become involved.

This is necessary, as we already find ourselves in a genuine therapeutic impasse.

Mr Alain-Michel Céretti thanks Dr Jean Carlet and gives the floor **introduces the presentation of Ms Anne-Gaëlle Venier**, Reporting Manager at the Southwest CCLIN, an organisation with which LE LIEN has collaborated since its creation.



Ms Anne-Gaëlle Venier explains that she is responsible for management of reports of rare and unusual nosocomial infections at the Southwest CCLIN. The CCLIN, of which there are five in France, has the mission of preventing healthcare-related infections. She in turn states that she is pleased with the collaboration instituted with LE LIEN.

The CCLIN, or coordination centre for control of nosocomial infections, a support organisation, has the aim of providing technical assistance and expertise to healthcare establishments and institutions, promoting the establishment of good practices, promoting and analysing the monitoring of healthcare-related infections, analysing variation in the risk, and offering training intended for professionals and for user representatives.

To do this, the Southwest CCLIN coordinates networks of professionals, conducts training, develops teaching videos, uses social media to transmit its messages, and for three years has produced “serious games”, that is, entertaining teaching modules using new information technologies. It also creates and makes available more standardised tools for preventing the occurrence of adverse events, such as risk assessment visit tools, analyses of scenarios, recommendation documents, practical guides, and informative documents (for example a brochure for the patient on the instructions to follow after cataract surgery).

The CCLIN provides its assistance if needed in the investigation of rare and unusual healthcare-related infections by promoting analyses of the causes and feedback.

To reply to what has been said previously, Ms Anne-Gaëlle Venier indicates that indeed the contribution of the environment in the occurrence of a healthcare-related infection deserves more extensive research, but she reminds that the effort on proper application of the standard precautions must also continue, hand hygiene in particular, which was involved in over a third of reports for the Southwest. But she ends her presentation on an encouraging note; the activities conducted are contributing to a decrease in healthcare-related infections.

CCLIN Sud-Ouest Centre de coordination de la lutte contre les infections nosocomiales



- Missions : prévenir les infections associées aux soins
 - Expertise et avis techniques pour les équipes d'hygiène
 - Établissements de santé et médicosociaux, professionnels libéraux.
 - Structure d'appui pour les ARS et de relai d'action pour les autorités
 - Crise Ebola, pathogènes émergents.
 - Formations et sensibilisation des professionnels et usagers
 - Animation de réseaux de professionnels,
 - Formations régionales des représentants des usagers,
 - Usage des médias sociaux : Twitter, YouTube, Pinterest.
 - Réalisation de « serious games » : Gale, Grippe, BHRé.

Vidéo didacticielles <https://www.youtube.com/user/gcclin/videos>
 Jeux sérieux http://www.cclin-sudouest.com/pages/info_Grippe.html
 Web <http://www.cclin-sudouest.com/> et <http://www.cclin-arlin.fr/>
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CCLIN Sud-Ouest Centre de coordination de la lutte contre les infections nosocomiales



- Missions : prévenir les infections associées aux soins
 - Créations d'outils pour améliorer la sécurité des patients
 - Visites de risque, analyses de scenario,
 - Plaquette patient opéré de la cataracte.
 - Gestion des signalements externes d'IAS en lien avec l'InVS
 - Aide à l'investigation
 - Promotion et réalisation des analyses des causes et des retours d'expérience : REX, lettre du signalement.
 - Suivre et analyser l'évolution du risque
 - Réseaux de surveillance et d'évaluation des pratiques.

Vidéo didacticielles <https://www.youtube.com/user/gcclin/videos>
 Jeux sérieux http://www.cclin-sudouest.com/pages/info_Grippe.html
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2nd roundtable Presentation of the LE LIEN association

Prof. Jean-Michel Dubernard, sponsor of Le Lien

Mr Alain-Michel Céretti, Founder of Le Lien

Ms Claude Rambaud, Vice President of Le Lien and of the CISS [Inter-association Health Collective]

Two questions:

What are the origins of Le Lien and its struggles?

What results have been obtained?

Mr Alain-Michel Céretti believes that it is important to remember the origins of LE LIEN. He cites the origin of the association in July 1997, his meeting with Bernard Kouchner, then Minister of Health, his desire to have a law on medical accidents adopted to avoid victims having to go through an “obstacle course for the recognition of their rights” (the “Clinique du Sport” affair).

When the association was founded, a large number of testimonials on medical accidents occurring throughout France were reported to LE LIEN. With regard to compensation of the victims of medical accidents, the advances made in favour of the victims of the Clinique du Sport (reuse of poorly sterilised disposable medical apparatus, rinsed in polluted tap water), opened the way for the Law of 4 March 2002 on the rights of patients and compensation for medical accidents.



In 1994, while he was a member of parliament, **Prof. Jean-Michel Dubernard** had submitted a bill on the creation of a compensation fund to benefit patients who were victims of medical accidents. According to him, there were several reasons for this initiative. On the one hand, he had acted as an expert on the matter. On the other hand, before his residency, on the occasion of a stay at the main Hospital of Harvard, he was struck by the establishment in the United States of genuine transparency of information intended for patients of healthcare establishments. This motivated him to attempt a transposition of these principles into French practices. This is also the main reason he agreed to sponsor the creation of Le Lien.

Therefore, in July 1998 he again submitted a new bill on the recognition of patient rights. It was then up to the Minister of Health at the time, Bernard Kouchner, to adopt the law on patient representation, the right of access to one’s file, and the creation of compensation for victims of medical accidents.

Prof. Jean-Michel Dubernard stresses how LE LIEN has played a key role in this progress. Today, he believes, it has become essential to coordinate all the initiatives; regional, like the antimicrobial cluster of Champagne-Ardenne, and national, in a European framework in close contact with WHO. There is a need to learn, share, and innovate for the welfare and safety of patients.

The screening of the film “*LE LIEN, 10 ans déjà*” (1997-2007), reviewing 10 years of activism, offers a vision and an overview of the activities conducted and the results obtained.

In picking up the subjects, the press has contributed extensively to informing and raising awareness in the general public, and so drawing the attention of political decision makers to the subject.

These efforts remain topical.



Ms **Claude Rambaud** succeeded Alain-Michel Céretti in the presidency of Le Lien in 2006. They contributed to the implementation of an extensive healthcare mediation system: healthcare access, discrimination, abuse, etc., at first with the HAS, then with the Médiateur de la République [*Ombudsman*] (now Défenseur des Droits). Through this activity, communication and a system for assistance for anyone who wants his rights acknowledged were developed. Alain-Michel Céretti now supervises implementation of this.

Ms Claude Rambaud recalls that she joined LE LIEN in 2004 after reading an article devoted to this association’s commitment.

With the perspective of a decade of association activity, she notes that in contrast to the period of confrontations characteristic of its first years, LE LIEN now takes the approach of partnership, in particular on the issue of patient safety.

The first victory of the association was to achieve the reform of sterilisation practices that led to the closure of a certain number of sterilisation services and a decree providing criminal penalties against managers and pharmacists of the establishments concerned.

The next victory was won with the creation of indicators, including the first, ICALIN, the Indice Composite des Activités de Lutte contre les Infections Nosocomiales [*Composite Index of Activities to Control Nosocomial Infections*]. LE LIEN launched this idea. The association supported its establishment in 2003, and has monitored it since that time.

Then came the first federal meetings organised in 2007 with the HAS and industry. Placement of hydroalcoholic solutions in all patient rooms and the creation of reference centres and “antibiotics” advisors (including the designation of an advisor in every establishment) were approved then.

The association took part in the Assises du Médicament [*Conference on Medicines Policy*].

The creation of the AC2BMR Alliance has resulted in significant advances.

LE LIEN has always adopted the motto “prevention is better than cure”. This is in particular the reason that the association supports trials of the use of copper to control nosocomial infections.

And yet, Claude Rambaud adds, the search for consensus, the preference given to negotiation and dialogue, must not lead to a renunciation of protest.

In 2007, for example, the French authorities were considering lowering the requirements for decontamination of endocavity ultrasound probes. LE LIEN immediately expressed regret that no prior study had been conducted on the potential consequences of such a decision. We encountered a purely circumstantial argument: “as long as there’s no complaint, there’s no issue”. Today, still, failure to decontaminate endocavity probes results in numerous victims who hesitate to make themselves known. So we must sometimes go back to confrontation to defend legitimate positions.

LE LIEN has therefore decided to re-approach the Minister on this subject. But many other struggles lie before us.

The sanction of failure to declare adverse events is a part of this.

A related question is furthermore raised as to the principle of the “patient as a co-participant in his safety”. It is that of penalising failure to inform the patient. The Conseil de l’Ordre des Médecins [*Medical Board*] stresses that the information is freely available and that it is up to the patient to request it. If the patient is a co-participant in his health, why should he not be co-responsible? But the culture of medical secrecy persists, which destroys patient trust. The future health law takes on this subject and the aspect of respect for patient rights.

Ms Claude Rambaud concludes that information must be part of the inviolable rights of patients.

At this point, some participants raise the question of the ethical and behavioural frontier that separates “*tell everything, with its possible effects on the patient*” from “*say nothing, which amounts to lying to him*”.

Ms Claude Rambaud notes that this question essential to the physician/patient relationship must now be treated in the course of medical studies in the programme dealing with risk management, teamwork, etc.

3rd roundtable

The WHO PFPS (Patients for Patient Safety) Programme



Ms Nittita Prasopa-Plaizier, Department of Service Delivery and Safety (WHO)

Ms Kathyana Aparicio, Department of Service Delivery and Safety (WHO)

Ms Margaret Murphy, PFPS Programme (WHO)

Ms Kathyana Aparicio starts by making an assertion: “We are all patients”. Whether a newborn, an adult or an elderly person who is a victim of a medical error is involved, everyone must be considered. Patient safety is a public health problem that concerns all generations and all countries, developed or developing.

Thus, it concerns all of us.

We must be aware that adverse events are foreseeable and thus avoidable. In 2002, the WHO decided to adopt a text on patient safety. In 2003, some countries took initiatives to this effect and the WHO provided technical support and created norms and standards.

Le problème de la sécurité des patients

Chaque année un nombre inacceptable de personnes dans le monde subissent des dommages et/ou décèdent des causes liées aux soins médicaux.
La plupart de ces cas sont évitables



In 2004, by resolution of the 57th General Assembly of the WHO, the World Alliance for Patient Safety was created. In 2009, the Alliance became a programme of the WHO.

The mission of the patient safety programme of the WHO is then to ensure that every patient throughout the world receives care based on the involvement of everyone, especially the patients themselves and their families.

The mission of the WHO also consists of making use of knowledge, experience and innovation, working with NGOs, committees, and patient associations, in short, all those who can contribute to improvement of the health of the public and of individuals.

In 2014, the WHO created a Department of Service Delivery and Safety focusing on patient safety and the quality of care.

The WHO programme includes patient participation, education, proper use of medications, primary healthcare, innovation, partnership, etc.

Involving patients in the safety of care is a priority.

But how should the WHO do this?

The challenge must be met despite the fear of families, the psychological trauma, and the “reputation” of individuals and of the system. But there are also opportunities available to the WHO to identify improvements with regard to safety and develop solutions by including family, patients and policy makers.

The patient and the family must therefore be at the centre of the activities. Everyone must be able to learn and educate themselves to act on a continuing basis. The WHO is working essentially toward the assumption of responsibility by, and transmission of power to, the patients themselves.



Ms Margaret Murphy, Global Manager of the patient safety network, begins her presentation by recalling the conditions under which she herself was led to join the PFPS programme of the WHO in Ireland. This was principally due to harm suffered by patients belonging to her family.

Patients pour la Sécurité des Patients

Partenariats pour une attention plus sûre

Réseau Mondial



Raconter des "histoires" pour catalyser des améliorations et l'apprentissage organisationnel

Favoriser la collaboration, la formation et orienter l'action vers la sécurité des patients dans le monde entier



Programme de l'OMS

Intégrer la voix du patient à tous les niveaux de la prestation des soins

Responsabiliser (empower) les patients et leurs familles en les aidant à plaider ensemble pour le changement

She believes that this is a good illustration of the fact that the patient and his family, when they have experienced at their expense incidents that have led to irreparable harm, are the best “ambassadors” to contribute to improving healthcare practices in all aspects related to care. Staying centred on the patient and his real needs, making the patient’s voice heard, in a collective, open, honest, responsible approach to reduce medical errors and the suffering they cause patients and families; this is developed in the working groups and workshops organised by the PFPS programme. To date the global network has over 300 members in 52 countries.

Relationships with medical students, teachers, and healthcare institutions are thus developed. They are supported by, among other things, communications on the work done by the PFPS in national or local periodicals. These active patients have become, in a sense unintentionally, participants in the transformation of negative experiences into sources of improvement in the safety of medical care and consequently the minimisation of future risks.

Mr Alain-Michel Céretti returns to the presentation of Ms Murphy and the participation of patients. He stresses how therapeutic education can allow the patient to become an expert patient with a high level of competence on the chronic disorder from which he suffers. He gives the example of the AFD [*French Diabetes Association*] which explains to young diabetics their future programme of treatment. LE LIEN does the same for the treatment for infections. With this information, patients have the feeling of being less isolated, as too often they feel abandoned. Contemporary medicine has dehumanised the relationship with the patient. This must be changed during medical studies, and medical empathy must be increased so that the person who is ill is not considered as just an organ that is ill. In the end, modern medicine has forgotten the person.



Ms Nittita Prasopa-Plaizier, after presenting an overview of the way in which work is organised at the WHO, spoke on the report on quality of care issued in 2002, of the involvement of the WHO as of 2003, then, in 2004, the creation of the World Alliance for Patient Safety.

In 2009, these initiatives were incorporated into the programme devoted to patient health with the objective of coordinating all the activities related to the safety of care. The central problem posed by patient safety is that every year an unacceptable number of people around the world who experience harm or even die for reasons related to medical care is recorded. But most of these cases are avoidable.

The Patient Safety Programme established by the WHO has consisted of setting up a strategy for the 2012-2015 period with the aim of ensuring that each patient receives safe healthcare, at all times and everywhere in the world. The WHO thus has the mission of coordinating, facilitating and accelerating improvement in patient safety at the international level. Its objectives are to ensure its global leadership in this field, to make use of knowledge, experience and innovation in order to improve the safety of healthcare services, and to work with healthcare systems, NGOs, professional organisations and the community of experts to support a solid and effective worldwide effort to benefit patients.

For this 2012-2015 period, its priorities focus on several themes: the participation of the community and of patients in the aspects of education, safety, healthcare personnel, safe injection and medication, African partnerships for patient safety and innovation in primary healthcare.

All these work topics, all this development, all this process of transition, have only one objective: to aim to achieve universal healthcare coverage with a healthcare process centred on the person.

To do this, the WHO works on a consulting basis with the PFPS network (strengthening interaction, communication and promotion), with policy makers (collaboration with national and international organisations), with academic institutions (creation and sharing of knowledge through research, education and training), with healthcare service providers (simplification of participation of patients in hospitals and healthcare centres), and with professional organisations and NGOs (collaboration with the NGOs and other organisations).

The WHO sets up workshops so that the patient no longer has the feeling of being neglected and is considered a “voice”.

Ms Prasopa-Plaizier recalls, on this occasion, that all the WHO participants are volunteers. Their activity is focused on the person. Putting the patient back at the centre of the issues must constitute an essential statement spotlighting, especially in the field of therapeutic education, the imperative to take into account the “pain” of each patient as a person.

Why should patient involvement be promoted? Numerous national and international publications have demonstrated the utility of this. Patient participation is a good way to prevent or alleviate medical errors, especially medication errors, and to report events that occur completely unnoticed. Studies have shown that 60% of families are ready to give their time to aid in preventing the recurrence of adverse events that have affected their children.

Patients have a key role to play in aiding healthcare professionals in arriving at a diagnosis and an appropriate treatment, but also in reporting adverse events. However, there are limiting factors; the asymmetric relationship between patient and caregiver, but also individual factors, including socioeconomic factors, which play an important role. The illness and its chronic nature on one hand and the vulnerability of the patient on the other hand can affect information literacy, that is, the ability to understand and use information. The patient is also not always ready to accept being a participant in his safety. There are also hindrances and fears among healthcare professionals; the patient's intervention can be perceived as an interference with their work.

There is still also the unfamiliarity of users with regard to their rights and the existence of user representatives and their role. This can explain, for example, the patient's reticence to come forward.

Patient involvement must obviously be promoted taking this context into account, to make him the number 1 participant in his own health.

This is why the PNSP has decided to recommend communication activities to promote patient involvement. It is important to acknowledge it as useful and legitimate. Poster campaigns, the week for healthcare safety and quality, and the publication of brochures, in particular those developed by the HAS for the patient so as to better communicate with healthcare professionals, physicians and pharmacists, are part of this activity.

Beyond these information campaigns, the question that arises is: *How can we make these communications high points last? How can we facilitate the involvement of the patient on a daily basis?*

There are various degrees of patient involvement. The first degree is to inform him about his illness, its treatment, the solutions, the possible alternatives; the second degree consists of asking the patient's opinion, listening to his feedback; the third degree is to involve him through a proactive approach that will ensure that his choices, expectations, concerns and aspirations are understood and taken into account. The most advanced degree is that of cooperation, a genuine partnership between patient and professionals. It is an approach of continuous co-construction with the patient and/or his entourage (where the patient must develop his decision-making power, putting him almost equal with the caregiver, for every aspect of alternative decision). This approach is present in Therapeutic Education, especially in the context of chronic disorders. This is now a reality, but still remains to be developed. The forms of involvement vary from one patient to another. A supportive approach must be undertaken in order to involve him in this teamwork (to take action with him and not for him).

To involve the patient, the PNSP has proposed the development of communication tools intended for professionals or patients that are inspired by international experiences. One of them, being developed by the HAS and intended for professionals, involves reformulation by the patient of the information dispensed by the physician. Another tool being developed by the HAS is intended for the patient and will have the aim of helping him speak with professionals, helping him ask them questions.

The direct involvement of the patient, the user, and the public in health monitoring is also provided in the PNSP, especially by the possibility that he will have of declaring an adverse event. Declarations of adverse events must be incorporated into the existing systems for reporting and declaration. All this is part of a medical landscape that has evolved.

While the number of patients who are victims of nosocomial infections has decreased due to the policy of reporting and prevention undertaken, adverse events related to healthcare remain an important public health problem that necessitates redoubled effort.

Involving the patient also means giving him an important place in the team. Numerous international publications have shown that when the quality of teamwork is improved, better treatment results are obtained for the patient. Thus, in the United States, a group of veterans' hospitals (108 establishments) was able to achieve an 18% reduction in mortality after a 4-year programme.

These publications have inspired the experimental programme PACTE (Programme d'Amélioration Continue du Travail en Equipe) [*Programme for Continuous Improvement in Teamwork*] conducted by the HAS in the framework of the PNSP. This programme relies on a self-diagnosis performed in a multi-professional team with a specific method (CRM health) that allows it to develop a plan of action to improve patient safety.

This involves making the issue of risk a collective issue. These "team reconstructions" based on non-technical competences (including stress management and communication) are essential.

Ensuring that the system functions between physicians and caregivers in the same department, in order to be able to elicit declaration of serious adverse events internally (to sound the alarm) is part of this. Medical and paramedical professionals must learn to talk about this together and conduct systemic analyses in the context of feedback.

Finally, the PNSP recommends facilitating the accomplishment of the missions of user representatives in healthcare establishments. By the end of 2015 the DGOS [*Directorate General of Healthcare*] will make a guide available to them for dialoguing with professional representatives on the theme of risk management and patient safety.

The process of appropriation of the PNSP tools must include general involvement (management of the establishments, of the regional support structures, of the CCLIN, of the user representatives, of the associations, etc.). It is essential now to keep up the efforts, to continue and to increase the means for taking action.

Mr Alain-Michel Céretti recalls that the PNSP must better take into account patient statements before an accident occurs. What is missing today, especially during hospitalisation, is for the statement of the hospitalised patient who reports an anomaly during his treatment to be heard without delay by the care team. The PNSP must insist more on this aspect. The PNSP provides that healthcare establishments make the means available to patients to report putative malfunctions.

WHO also emphasises this. The patient must be at the centre of the issue and remain alert regarding the management of the care process. And a reporting system must be put in place in every room. This subject is not an option. This is the first expectation of patients.

4th roundtable
Healthcare safety: still more - the new challenges
Environmental infectious risk
Safe management of materials and fluids

Mr Olivier Toma, President, C2DS

Ms Claudine Richon, Administrative Member of LE LIEN and Consulting Engineer in healthcare prevention

Mr Benjamin Galle, Quality Manager, Rambouillet Hospital

Ms Amélie Gélis, Manager of Clinique Arago,

Mr Charles-Antoine Benhamou, General Manager of Hôpital Privé Nord Parisien,

Prof. Bill Keevil, Director of Environmental Health Laboratory, University of Southampton



Mr Olivier Toma, President of C2DS, opens this roundtable on environmental infectious risk and safe management of materials and fluids.

The basic idea of the C2DS association was to say “let’s try to make healthcare establishments ‘virtuous’ in their management, maintenance, etc.” The idea was also to be preventive starting from the construction of a healthcare establishment. This is why the association has worked on eco-design, for which a guide has been produced.

The mission of this guide is to provide tools during the construction of a hospital in France. Six spokespeople were assembled to raise awareness of all the emerging and known risks on which healthcare establishments are already working.

Question: *What is the importance of developing the concept of sustainable development in the healthcare sector?*

Eco-design has been discussed with 430 regional healthcare establishments. The regulatory context is abundant (texts of “Grenelle 1 and 2”): 257 articles of law will fundamentally transform establishments. Another regulation established in France is the Stratégie Nationale de Transition Énergétique vers un Développement Durable [*National Strategy for Energy Transition toward Sustainable Development*].

It allows France to better negotiate this ecological transition and to reduce energy consumption, and thus the associated greenhouse effects, by over 30%.

Another tool, the third Plan National Santé-Environnement [*National Health-Environment Plan*], PNSE 3, the development work for which was launched in 2013, is presenting a 2015-2019 project with essential activities. A summit on global warming will be held in Paris in December 2015. France would like all countries to start on the path to reducing greenhouse gas emissions. France would like to promote its exemplary behaviour in this area.

However, there are roadblocks in this process, the multitude of data on our significant impacts creates confusion over the contradictory information, visible on the internet in particular.

Question: *How can these issues be understood?*

The second aspect of this process reveals a lack of training of healthcare personnel (from the director to the nurses) and managers of healthcare establishments on awareness of environmental risks. They therefore search on the internet. Neither the ARS [*Regional Health Agencies*] nor the Ministries provide ongoing information. And this also concerns the users, who should be better informed. The idea for them is to identify the environmental and sanitary risks.

How can the effect of respiratory pollution due to toxic gas emissions be translated into terms of health issues in the form of figures allowing the impacts on health to be measured? How can it be conveyed in the form of a barometer for healthcare establishments?

Not forgetting that we must also protect the employees.

Some subjects are currently treated in healthcare establishments. About a hundred establishments have provided figures on their production of chemical emissions. But the lack of training on these topics among the public, as well as healthcare personnel is quite perceptible.

However, there is no shortage of topical subjects for these establishments: the carbon footprint, exposure to chemical products, endocrine disruptors, nanoparticles, medications and their environmental impact, hypersensitivity and multi-resistance, magnetic fields and the quality of indoor air. These are issues and challenges for the years to come. It is thus essential to identify and support the healthcare establishments involved in this mission by sharing good practices, speaking out against poor ones, training and sharing knowledge, backing innovations, and encouraging strategies for alliances between healthcare industries and patients.



Ms Claudine Richon then takes the floor.

She made LE LIEN aware of the bactericidal effects of copper during its 2011 Conference. She characterises her approach by the discovery in 2009 of sustainable eco-health and the research conducted on the subject.

It is said that innovation is the rediscovery of existing contexts. This is the case with copper and its alloys with regard to their preventive virtues related to sustainable health. Copper has been used since 7000 B.C. in India. In our time, experiments have been conducted in healthcare establishments around the world (USA, England, Chile, Germany, Finland, France, Greece, Japan, etc.) in public and private hospital units and on patients in hospitals and in rest homes.

EXPERIMENTATIONS DANS LE MONDE



USA

3 établissements hospitaliers - **The Medical University of South Carolina, Charleston (MUSC), The Ralph H Johnson Veterans Administration Medical Center, Charleston, South Carolina and the Memorial Sloan Kettering Cancer Center in New York City**

Angleterre

Selly Oak Hospital, Birmingham, Professor Tom Elliott, Consultant Microbiologist and Deputy Medical Director at University Hospitals Birmingham NHS Foundation Trust

Chili

Hospital del Cobre, à Calama, essai Clinique sur 30 semaines en soins intensifs (ICU)

Allemagne

Asklepios Clinic, Wandsbek près de Hamburg, remplacement de poignées de porte en aluminium et d'interrupteurs en plastique par leurs équivalents en alliages de cuivre en secteur EHPAD

Finlande

Essai Clinique en maternité sous l'autorité du Helsinki University Department of Public Health

Autre pays

France, Espagne, Afrique du sud, Grèce et Japon

ETUDES SUR PATIENTS EN HÔPITAUX & MAISONS DE RETRAITE



Etude américaine sur patients du Pr Schmidt sur la diminution du taux d'infections nosocomiales

OBJECTIF : montrer que le cuivre permet de réduire le taux d'infections chez les patients
RESULTAT : 58% de réduction obtenu

2011 Etude française sur patients hôpital de Rambouillet

- En tant que R.U pour LE LIEN au CH de Rambouillet, proposition à la Direction de l'hôpital de mener une étude sur patients pour évaluer le bénéfice patient dans le cadre de la prévention contre les infections nosocomiales

2014 Expérimentation patients sur 5 EHPAD de Champagne-Ardennes

The results of these studies reveal that in the chain to prevent environmental cross-transmission and infectious risk, one cannot omit proven good practices and the promotion of hand hygiene recommended by WHO. Copper must be considered a “link with antibacterial proprieties” constituting an additional non-negligible benefit for the patient.

An American study published in 2011 demonstrates a reduction of 58% in the level of nosocomial infections in patients in intensive care units equipped with copper contact surfaces.



Mr Benjamin Galle then presents an evaluation of the efficacy of copper against bacteria in his healthcare establishment, the Rambouillet Hospital.

This project was initiated in 2011. The Rambouillet Hospital wanted to participate in this trial by establishing an active policy with regard to prevention of nosocomial infections. With this aim, the Hospital decided in 2011 to equip two test units (paediatrics and adult and neonatal intensive care) with copper or copper alloy fittings in the immediate environment of the patient, without modification of the practices of the caregivers.

In paediatrics, there are peak epidemic periods. Moreover, parents who accompany their children while they are hospitalised, often spending day and night with them, can increase the risk of transmission of infections like viral gastroenteritis, which is known for being highly contagious, in these units.

Two periods characterise the test with regard to methodology: before and after installation of copper fittings. Mr Benjamin Galle explains that it was required that the practices of the caregivers not be changed.

In this first portion of the trial (effect of copper and copper alloy equipment in a paediatrics unit) the results, according to Mr Benjamin Galle, are not sufficiently conclusive at this stage.

On the other hand, in the trial conducted in the intensive care units, the results seem highly encouraging.

In fact a drop in the number of acquisitions of multi-resistant bacteria has been recorded. Two concomitant factors must however be specified: the perceptible accompanying increase in use of hydroalcoholic solutions by the caregivers, and a reduced severity in the patient cases treated in the unit.

The Rambouillet Hospital is therefore continuing to explore the efficacy of copper in the long term, aware of the induced preventive contribution.

Dr Patrick Pina, Head of the Operational Hygiene Department of Rambouillet Hospital moreover commented that no hindrance was noted in the units during this process. Both teams in fact were favourable to this trial and would not want their antibacterial copper equipment removed now for anything. While it is reasonable to remain cautious in the interpretation of these results, the fact remains that the level of acquisition of multi-resistant bacteria in the establishment has clearly dropped.



Ms Amélie Gélis, Director of the Clinique Arago, speaks on the management of environmental infectious risk in a healthcare establishment devoted to orthopaedics and talks about the experience of her establishment, specialised in arthroplasties of the hip and knee.

She stresses the fact that, despite technical developments, an infection involves recovery and long-term sequelae.

Question: What is the strategy for controlling infectious risk and nosocomial illnesses in a private establishment, considering the example of the Clinique Arago, specialised in orthopaedics and in particular arthroplasty of the hip and knee?



La clinique Arago en quelques chiffres

- Clinique parisienne spécialisée en arthroplasties de hanche et genou
 - 17 chirurgiens en majorité monosite
 - Activité 2013:
 - 1091 ATH / 548 ATG
 - 170 reprises d'arthroplastie
 - 20 patients en cancérologie osseuse



Progress in orthopaedic surgery and in particular arthroplasties is such that the patient can expect a perfect result. The only limitation is the occurrence of a complication. The infectious risk remains the most serious risk for the patient. The approach to risk management has evolved over the years. Schematically, three major periods have been identified in the development of the Clinic.

First of all, application of the recommendations on good practices. Then, the implementation of the procedures of the Société Française d'Hygiène Hospitalière [*French Hospital Hygiene Society*], the ANSM [*National Agency for Medicine and Health Product Safety*] or the HAS. Finally, the implementation of its risk management process: references to the procedures of various authorities (in particular CCLIN), installation of IT in the patient room (highly beneficial, especially in traceability of the patient and his preparation), and connection of the patients with specialised centres (Orthorisq). Successive certifications have allowed the Arago clinic to formalise its practices and involve all the professionals in the risk management process.

Simultaneously, patients have been informed of the clinic Management's approach, which has conducted audits and published the indicators. Despite the development of short stays with lower risk, the establishment has opted for monitoring the hematoma risk. The establishments have chosen to no longer put patients in rehabilitation centres. Signs of post-operative reaction must be explained. There must be early treatment. Pre-operative and post-operative meetings are organised with the patients.

Ms Amélie Gélis explains that the clinic became aware of what it did not know how to do well by approaching specialised centres. The results over five years are encouraging and validate the idea that their approach is correct. These results allow the new challenges that lie before the clinic today to be understood. The first challenge is the rapid development in patient treatment. The trend is toward reduction in the stay, even outpatient treatment, including for prostheses.

● ● ● | La clinique face à ses nouveaux défis

- L'accourcissements des durées de séjours
 - « Pression » de l'ambulatoire

Une hanche opérée en ambulatoire, une première en France

« Un patient sur cinq pourrait être opéré ainsi. » Dr Grégory Biette



● ● ● | La clinique face à ses nouveaux défis

- L'accourcissement des durées de séjour: Quel impact sur le risque infectieux?
 - Retour sur l'expérience danoise
 - Les risques d'une sortie trop précoce
 - Survenue et gestion de complications médicales
 - Nécessité d'éducation du patient avant l'hospitalisation
 - Nécessité de création de structures allégées



The reduction in the length of stays must necessarily be taken into account. What are the consequences, for example, for the joint drainage left in place three days after the placement of a prosthesis for which prospective monitoring of hematoma risk will be conducted?

Establishments are strongly encouraged to no longer send patients to specialised centres but to send them home. Caregivers must therefore be present more often. Clinic operators leave their contact details more and more. Preparatory meetings are organised, and home care is advised. The establishment of medical hotels along the lines of the accommodations offered in the United States is expected.

The Arago clinic encounters severe constraints on facilities, like a good number of Parisian establishments. It has had the opportunity for financial support in order to move to the site of the Paris-Saint-Joseph health group and increase its accommodation capacity (from 55 to 66 beds). It aims to become a centre of excellence for prostheses in Paris.

Henceforward the clinic will benefit from a large area and circuits guaranteeing the water quality, with laminar flow in the operating theatre, allowing for procedures under ideal aseptic conditions. In addition, orthopaedics requires a great deal of equipment and stock, which tend to block the corridors of operating theatres. Large electrical storage cabinets that allow space to be better managed and protect the backs of the operating theatre nurses have therefore been purchased.

The Arago clinic knows the positive role of certain materials on bacteria in orthopaedics in situations with very high infectious risk, as in the case of a large prosthesis after a tumorectomy. In the course of the collaborations between the Clinique Arago and LE LIEN, increased awareness of the bactericidal effects of copper has led the establishment to install door handles and handrails of antibacterial copper alloy in the hospitalisation and walking units of the new building. Henceforward, indicators will be set up to allow the preventive effects of these fittings to be measured in a more advanced way.



Mr Charles-Antoine Benhamou, General Manager of the Hôpital Privé Nord Parisien, presents his establishment. It includes four major centres: maternity, dialysis, oncology and surgery, as well as a downstream “oncological follow-up care” unit. It is focused on risk management and taking account of infectious illnesses, but also, due to its positioning, on quality and innovation. It has participated in work on the properties of copper to confirm the studies and properties that have been reported *in vitro* in an *in situ* situation in the establishment. This is why it chose the “oncological follow-up care” unit, as these patients are deemed to be at greatest risk. The trial that was conducted necessitated the resolution of technical problems as well as the establishment of protocols.

From this study, Mr Charles-Antoine Benhamou observes that there are highly encouraging results obtained in the units equipped with antibacterial copper door handles.

He adds that moreover, as he has been aware of the subject for a number of years, a campaign was launched in 2011 in all the units of the establishment to study the levels of VOCs (Volatile Organic Compounds) present in the air of the establishment. This concept was poorly managed. The first campaign raised awareness that these levels could be significant, given that there exists a classification with several stages.

In this first campaign, the establishment revealed that it was sometimes beyond the recommended limits in certain premises. This explained why the air was polluted and that it was necessary to aerate, and why CMV was important to renew the air in a confined environment. These problems were resolved.

Then the establishment became interested in the sources of these volatile organic compounds that are often present in establishments. It is always possible to reduce them, especially in relation to cleaning. Cleaning products were specified and good practices were developed. In the event of renovation or construction, these specifications and specific materials can be required of service providers, partners, and outside participants.

These materials are more and more well-known (adhesives, furnishings, paints, etc.). Standards have been imposed in order to be preventive and not curative. The patients benefit from this improvement, even if it is for a short time. On the other hand, professionals spend numerous hours in the location. And so, it is completely appropriate here to strive for wellbeing at work, thanks to this improvement in indoor air quality that also includes avoiding the use of materials that release nanoparticles. The establishment is working on this, especially with the “mother and child” centre that is seeking to become an especially vigilant “eco-maternity” centre.

The last example of the establishment’s involvement concerns not only the patients and healthcare professionals, but also the outdoor environment. The establishment has become interested in studies regarding the discharge of medications in wastewater, the impact of which is difficult to measure. The establishment of the PBT (Persistence, Bioaccumulation and Bio-toxicity) index that traces the impact of, among other things, medical residues found in water allows a classification.

The entire establishment (practitioners, prescribers and caregivers) has been made aware through the use of this classification, which has been introduced into the drug formulary so that in their future prescriptions they take into account this idea; between two medications with equivalent properties, one can have greater or lesser consequences for the environment.

The establishment is now searching for tools to assist prescription so that this is not too complicated for the practitioners. The hospital hopes to generalise this concept in order to reduce discharges and water contamination that concern the entire population.



Professor Bill Keevil, Director of the Environmental Health Laboratory of the University of Southampton gives a slide presentation on the theme “Breaking the chain of infection”.

He opens his remarks with a deliberately provocative question: If an airliner crashed with its 200 to 300 passengers every day, would we still consider taking an airplane?

With this metaphor Professor Keevil alludes to the 350 American patients who die each day of nosocomial infections due, in large part, to bacterial multi-resistance phenomena, while American civil aviation statistics count only 153 deaths between 2001 and 2011, or two deaths per 1000 million passengers.

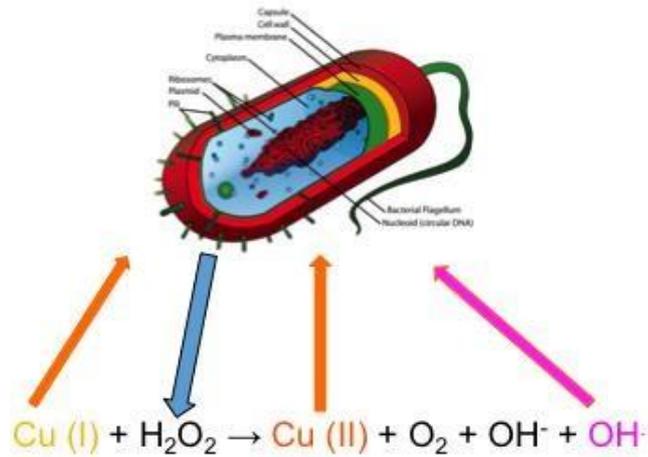


A 2011 WHO report shows that nosocomial infections in the European Union have a prevalence up to 51% in intensive care in the EU countries.

A few figures reveal facts that are more than worrying: every year 4.1 million patients are affected, which represents 16 million additional days of hospitalisation and a budgetary impact for health of €7,000,000,000; 37,000 deaths are recorded. Eighty percent of infections are spread by touch. Deficiencies in the manual establishment of decontamination measures are also noted.

The work done on antibacterial copper led Professor Keevil to study and understand the antibacterial mechanism of copper, which acts on water-borne pathogenic agents (*Legionella pneumophila*, *Helicobacter pylori*, *Escherichia coli*), food-borne pathogenic agents (*Escherichia coli*, salmonella, *Listeria monocytogenes*), and nosocomial pathogenic agents (MRSA, VRE, *Clostridium difficile*, *Klebsiella pneumoniae*, *Candida fungi*, the H1N1 influenza virus, norovirus, adenovirus). When copper is used, there is complete destruction of the germs in 5 minutes, 10 minutes for bronze and brass, versus 20 minutes for nickel silver (a copper-zinc-nickel alloy).

Bacterial metabolic suicide on Cu



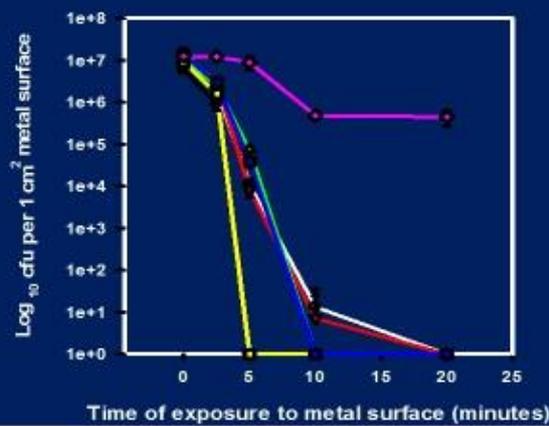
- Rapid 200,000x uptake of Cu(I) in seconds and attack
- Generation and attack by Reactive Oxygen Species

Rapid death of *K. pneumoniae* encoding *bla_{NDM-1}* on copper and alloy surfaces: dry inoculum

Complete kill within 5 minutes occurs on copper and copper nickel ;
10 minutes for phosphor bronze and cartridge brass and 20 minutes for nickel silver and muntz metal.

●	copper C11000 (100% copper)
●	Muntz metal C28000 (60% Cu; 40% Zn)
●	Nickel silver C75200 (65% Cu; 17% Zn; 18% Ni)
●	cartridge brass C26000 (70% Cu; 30% Zn)
●	copper nickel C70600 (89% Cu; 10% Ni; 1% Fe)
●	Phosphor bronze C51000 (94.74% Cu; 5% Sn; 0.29% P)
●	stainless steel S20400 (74% Fe; 18% Cr; 8% Ni)

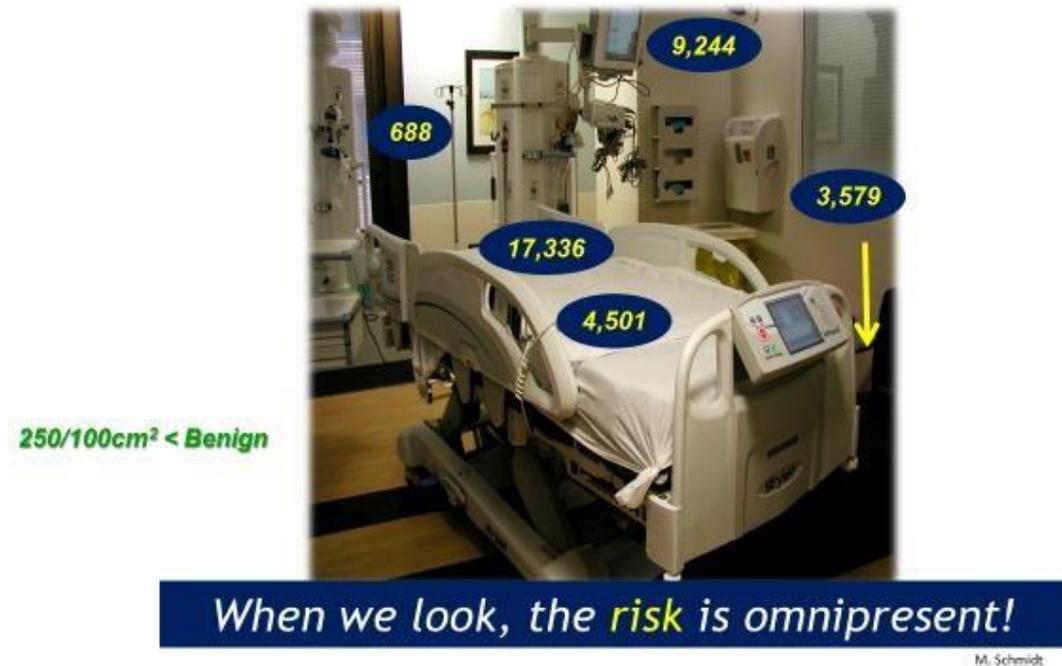
Survival of *Klebsiella pneumoniae* NCTC 13443 (NDM-1) on metal surfaces at room temperature 'dry' inoculum 120811



Warnes et al. mBio 3, e00489-12 (2012)

To measure the effect on the patient of frequently touched contact surfaces, a count of the germs present in the patient's environment in the resuscitation room was conducted. The result is clear, and given that more than 250 bacteria per 100 cm² represent an infectious risk for the patient, it is easier to understand the infection rate of one patient in twenty.

Question: *What can be done to change this?*

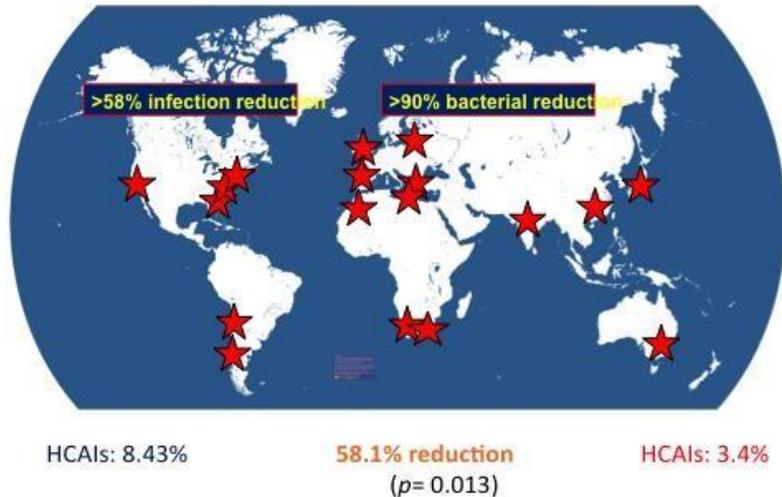


A comparative study with copper and copper alloys contact surfaces was conducted, with a germ count on the contact surfaces in 16 resuscitation rooms for 21 months. On the bars of beds, copper reduced the number of bacteria present by a ratio greater than 17.



Various studies conducted around the world conclude that there is a reduction by more than 90% of bacteria present on copper contact surfaces, associated with a reduction in the rate of nosocomial infections of 58%.

Ward Trials Worldwide



These tests conducted on a global scale have proven that copper acts as a “disruptor” that eliminates bacteria. Copper contact surfaces are an additional preventive measure to control infections.

This research demonstrates the challenges faced by numerous healthcare participants in controlling nosocomial illnesses.

5th roundtable Health democracy Resources for patient involvement

Dr Jean-Charles Leclerc, Radiologist, FNMR [National Federation of Radiological Physicians] & Labelix

Mr Alain-Michel Céretti, Founder of Le Lien

Dr Bruno Favier, Medical advisor, Caisses d’Epargne Foundation for Social Solidarity

Mr Alain-Michel Céretti presents Dr Jean-Charles Leclerc, quality advisor for ultrasound and radiology. He specifies that Dr Bruno Favier will speak in the context of the work conducted by the EHPADs managed by the Caisse d’Epargne Foundation for Social Solidarity. LE LIEN is highly committed to having specific age-related issues fully taken into account in care-related risk management policies, in particular, for instance, infectious risk and drug-related iatrogenesis.



Dr Jean-Charles Leclerc represents general practice and also, through the development of his Labelix quality procedure, public radiology units and hospital establishments.

For him, the question is the evaluation of practices. This question raises another, more fundamental question: “When one is a physician, can one evaluate one’s own practices? And if one does so, what areas for improvement does one put in place? Finally, is there verification of what has been done?” The quality procedure involves improvement in patient treatment. The Labelix procedure puts the patient at the centre of these issues. The discussion therefore has involved better treatment of patients in medical imagery facilities.

As a private radiologist, to start, a certain culture of quality has been acquired thanks to the historic implementation of mammography in breast cancer screening. It involves training the personnel performing the examination, training physicians, and internal and external quality controls. A second reading has been set up (review by a second radiological physician for greater safety). This quality procedure was initiated over 10 years ago with pilot sites. Today, 120 facilities are approved or are in the process of approval.

A quality procedure is based on a reference guide that details the procedure for the radiology practice to follow in ten chapters. Eight of these chapters cover the entire practice from the time the patient enters the facility, with consideration of all the regulatory obligations, to the transmission of the report to the physician. This reference guide is constantly evolving. Two chapters are quality management tools inspired by the ISO 9001 standard.

Labelix is not a certification of the medical procedure itself. It aims to ensure patient treatment under the best possible conditions. In practice the imaging centre will define high-priority areas for improvement and then implement them. It then performs a sort of trial audit to verify that the solutions have in fact been implemented. At the end of approximately 3 years on average of work to improve practices, an external audit will be performed in order to obtain an approval valid for four years, subject to verification midway through. Thereafter, in order to ensure a process of continuous improvement, regular meetings of the steering committee are held with regular follow-up, treatment of adverse events and satisfaction surveys.

With regard to safety, to illustrate the theme of today’s colloquium, Dr Jean-Charles Leclerc listed four types of safety:

- 1- The safety of the emergency cart, which must be complete. This also involves training physicians and caregivers and doing regular drills, and having very simple forms. Traceability of the consumables on the emergency cart must be strictly managed.
- 2- Fire and IT safety.
- 3- Hygiene, which is also central to Labelix approval. The work done in private and public establishments involves traced commentary and management.
- 4- The field of radioprotection, which is obviously central. Patient exposure must be measured, the dose noted and this information transmitted to the institutions. This involves follow-up and very rigorous maintenance of the equipment. Tools have been developed, such as software that allows practices to be evaluated and precautions to be set up, especially for dealing with pregnancies. The radiation dose appears in the report.

Thus, a quality procedure allows practices to be evaluated and action taken as a consequence, with a constant reduction in the doses received.



Dr Delgoffe centre J. Callot Nancy

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By way of illustration of the procedure, Dr Jean-Charles Leclerc presents the example of the reduction in the dose received by a patient for a scan of the lumbar spine over a period of 3 years as a function of the various actions taken.

In conclusion, the Labelix procedure allows treatment of patients in imaging facilities to be improved at various points in their visit to a radiology practice, with a particular aim: to put patients at the centre of the radiologists' concerns, while ensuring them care with maximum safety. The desire of radiologists is now to establish this quality procedure in all imaging facilities, as currently it is not recognised by all administrations.

Mr Alain-Michel Céretti notes that the quality procedure is not promoted or recompensed. Its "drivers" remain invisible, and lack of quality is not penalised. He regrets that we are seeing a levelling downwards, counter to the interests of patients.



Dr Bruno Favier, a physician with geriatrics training, wants to re-examine three points:

- In the first place, the conclusion of a 2008 HAS hearing that said, in substance: "let us refer to the common law that should apply to handicapped persons, although sometimes it is not adequate and something else must be invented". Six years after this conclusion, Dr Bruno Favier specifies that it remains pertinent. The medico-social sector is ahead on exactly this point, in particular in the aspect of health democracy in the establishments.

- In the second place, geriatric and gerontological medico-social care and support systems could be adopted in the health establishments. While most people working in medico-social establishments or establishments dealing with handicapped or highly dependent persons come from a health training background, it is essential in the future to hope for feedback from the medico-social sector, geriatrics and gerontology to healthcare.

- In the third place, the inadequacy of the available data that complicates application of initiatives must be recognised. Dr Bruno Favier is convinced that the problems of pathologies, and in particular of risk or of infections, were not recorded before LE LIEN proposed to do so during its 2007 conference. The generally accepted infection rate associated with care in an EHPAD was 4 to 5%, while a study by the Observatoire du Risque Infectieux en Gériatrie (ORIG) [*Observatory for Infectious Risk in Geriatrics*] done in 2008 - 2009 showed that it was in reality nearly 10%.



Quelques spécificités des usagers du secteur médico-social

- Fragilité médicale et vulnérabilité sociale;
- Protection juridique;
- Obligation de sécurité, et liberté d'aller et de venir;
- La famille: Place revendiquée et place accordée;
- Déontologie versus éthique.

Fragility is a risk factor that must be accepted by the patient. Many people (800,000 in France) accommodated in these centres are protected by a legal measure.

The safety obligation and the freedom to come and go are principles that are not easy to combine when a person is confined in a room. This risk exposure must be explained to the patient.

Since 2002, the legislator has given an important place to the family via social life councils. This highly interesting health democracy tool could be exported to some establishments.

Finally, deontology remains an inviolable reference. In some establishments, it can prove to be contrary to ethics.

It must also never be forgotten that some of the patients/residents have cognitive disorders. The choice of care personnel must be precise. Their way of expressing themselves is decisive. Semantics is not irrelevant, as some of the words used can prove to be incomprehensible for the patients. It therefore seems important to clarify communication with the patients or residents by training or identifying good spokespeople.

The involvement of the establishments with regard to pathologies is to be determined. This is an exercise in health democracy which no one in the establishments can evade. It must be used by creating new tools.

As a reminder on the tools in the 2002 law: legislators proposed seven tools for managing the personal life council and the residence contract (personalised care plan).

Among these, three tools are stressed: the social life council, the qualified person who is not yet present in all establishments in 2014, and the residence contract, which is not necessarily a health democracy tool as such, but the annexes of which are mandatory: a personalised living or care plan.

The proposals that have been made and approaches that are followed are: initial training of all caregivers (it has been proposed that each person come to an establishment of this type to learn the tools, the language and the way to care for people with a handicap), and therapeutic education of patients (*éducation thérapeutique des patients*, ETP) for patients with Alzheimer's, which is not used in the establishments at present.

Despite the support of aides, systematic approach and analysis are not used. And it must also be noted that mediation is not used in all establishments with the same efficacy and involvement. Nine ARS are testing out PAERPA (*Personnes Agées en Risque de Perte d'Autonomie*, Elderly Persons at Risk of Losing Autonomy), the aim of which is to expand to pathologies other than vulnerable people and care sectors other than the medico-social.



Quelques propositions et pistes

- La formation;
- L'éducation thérapeutique des aidants naturels et des professionnels;
- L'approche et l'analyse systémique;
- La médiation;
- Les parcours de santé et de soins centrés sur les usagers ou les résidents (exemple des PAERPA).

LE LIEN began to question the fate of the dependent elderly in these establishments very early. The association noted that the policies on infectious risk and everything relating to health democracy had begun in healthcare establishments rather than in medico-social establishments, while the patients in the medico-social establishments need much more attention as they are more vulnerable. The medical authorities are making progress in this difficult subject of health democracy, as the patient is generally integrated into these facilities over several years. Complaints are not expressed in the same way.

6th roundtable

The patient

Target and stakeholder in a health organisation at his service

Perspectives

Ms Claude Rambaud, Vice-President of Le Lien

Ms Nittita Prasopa-Plaizier, Department of Service Delivery and Safety (WHO)

Katthyana Genevieve Aparicio-Reyes, Department of Service Delivery and Safety (WHO)

Ms Claude Rambaud recalls a simple principle that is the very foundation of the activity of Le Lien: *There's nothing better than prevention to avoid occurrence of an adverse event.*

Indeed, the ideal is that the adverse event doesn't occur. Foresight is knowledge. But what do we know about iatrogenesis? Despite the collection of international data, the figures are difficult to obtain in France. We have those that involve mortality, of 15 million hospitalisations, one hospitalised patient in 300 dies of a medical accident; 50% are avoidable. This raises questions.

In France, causes of death are poorly evaluated and poorly monitored. This is why non-declaration must be penalised. The importance and quality of information are essential for better prevention. Information is an essential principle of treatment.

What information does the patient need? In France, can the patient get access to his file anywhere or anytime?

In the United States, the patient can download his file at any time. We have not now reached this point in France. Access to medical information is still difficult. LE LIEN is in favour of open access to data.

Ultimately, in the French system, the decision in anything concerning the relationship with the patient is up to the director of the establishment. Therefore, LE LIEN demands that there be a patient safety authority in every healthcare establishment.

He should have resources identical to those that personnel safety has with regard to alerts, investigations, even a genuine veto right against poor practices. Only then would it be up to the director to take on his responsibilities. But this is absolutely not the case now. This is why LE LIEN has decided to promote such a patient safety authority. This exists in large companies, where the Comité d'Hygiène, de Sécurité et des Conditions de Travail (CHSCT) [*Occupational Health and Safety Committee*] has a right of veto against the company manager and can suspend an activity if it is considered hazardous.

More generally, with regard to promotion of quality, LE LIEN is pleased that in the health insurance financing law that has just been adopted, Article 46 incorporates the implementation of quality indicators in the establishments and opens several new perspectives that move in the right direction.

Although LE LIEN regrets that the law provides for penalising establishments whose indicators are inadequate, as penalising an establishment means penalising its budget, therefore penalising the patients.

Ms Claude Rambaud claims to be optimistic nonetheless as, according to her, even if the advances recorded are modest, they reveal that a change in awareness has taken place, which bodes well for the future.

Ms Nittita Prasopa-Plaizier broadens the perspective. She recalls that the mission of the WHO is to guide and coordinate international healthcare activity. It aims to achieve the highest possible level of health for people everywhere. The text of the 1948 preamble to the Constitution of the WHO says that *“Health is a state of complete physical, mental and social well-being and not merely the absence of disease or infirmity.”*

The WHO, with headquarters in Geneva, represents 194 member states and brings together over 7000 persons in 150 countries through six large global regions. Service Delivery & Safety (SDS) is attached to the Health Systems and Innovation (HIS) Department. The service in charge of patient safety and improvement of the quality of care is located within this Department.

WHO policy is focused on the place of the patient; the individual must be central to the concerns of healthcare participants.

The policy of universal healthcare coverage must be innovative and convey values. Giving power to patients is essential, as is putting the accent on his safety (clinical, human, economic, etc., problems). Patient safety is a global topic. The WHO has identified and is working on various themes that recur regardless of the country; for example, safety practices with regard to prevention of infections, injection or transfusion, checklists, emergency vital and surgical care, and education of the patient and his family on healthcare safety.

If in particular a key question like that of dangerous injection practices and overuse of injections is considered, it is alarming to note that 6% of single-use syringes are reused on patients and lead to 1.7 million new infections due to the hepatitis B virus, 350,000 new infections due to the hepatitis C virus, and 75,000 new infections by HIV; the total comes to 1.3 million deaths annually.

This type of alarming observation obviously guides the WHO in its policy. Thus, its patient safety programme has instituted measures aiming to change the behaviour of healthcare professionals and healthcare institutions by limiting the use of injections, but also by launching a global safety programme on the use of syringes with the aim of protecting both patients and caregivers.

This policy can be examined from another essential perspective, that of partnership. Partnership is recognised as a highly innovative focus in improvement of patient treatment. The idea is to have different entities collaborate in a common aim by establishing a relation of mutual trust.

The WHO is proposing total involvement of patients and their families in order to implement its global policy incorporating establishment of universal health coverage centred on Quality and Personal Safety. This point was addressed in the WHO's global Consultation of experts and managers on patient and family engagement at WHO Headquarters on 27 and 28 October 2014. Patient involvement must be increased if they are to be able to participate fully in their course of treatment.

The commitment to safety and quality of care aims to respect the desires and needs of each patient by aligning with his values.

Universal healthcare coverage in the sense of the WHO must allow every patient to take advantage of the care he needs without financial difficulty according to his situation in the treatment system.

For the 2014-2023 period, the WHO has adopted the following objectives:

- constructing a knowledge base necessary for better management,
- strengthening quality assurance, safety, proper use and efficacy,
- promoting universal health coverage by integration.

This is moreover a continuation of the policy that inspired the PFPS, Patients for Patient Safety, programme that was created in 2005 as a pillar of the world alliance for patient safety.

It consists of giving patients responsibility and promoting their leadership, making their voice heard by caregivers and politicians, collaborating with those involved and facilitating patient participation. This implies providing technical support for local appropriation, making use of and contributing to the production of resources, identifying deficiencies and setting the research programme, proposing innovation and involvement as effective solutions, and promoting ties and creating partnerships between those involved.

Today the PFPS global network includes nearly 400 "peer ambassador" patients to ensure their mutual safety in 54 countries.

Roles of WHO Patients for Patient Safety

- Empower patients and promote patient leadership
- Advocate to bring the patient voice to health care, services and policy
- Collaborate with stakeholders and facilitate patient engagement
- Provide technical support - for local ownership and local capacity
- Harness contributions and produce evidence-based tools
- Identify gaps and set research agenda
- Propose innovation and engage in innovative solutions
- Promote connections and create partnerships among stakeholders



World Health
Organization

In this capacity, the WHO recalls how much it has learned by working with the poorest countries, with poorly developed healthcare systems.

Today, the WHO strives to create relations of solidarity between the various countries in order to allow information from all parties to circulate in the collective interest of the patients.

In Canada and Malaysia, implementation of the PFPS network established by the WHO is especially active. Organisations or institutions grant their support to these networks and campaign for improvement of the healthcare system for the benefit of the patient.



In order to illustrate her remarks, **Ms Kathlyana Genevieve Aparicio-Reyes** then presents to the participants and comments on the following items of information.



Lancement en 2004 de la "World Alliance for Patient Safety" Alliance Mondiale pour la Sécurité des Patients, avec Sir Liam Donaldson en tant que Président

En 2009 l'alliance devient "WHO Patient Safety Programme" - Programme pour la Sécurité des Patients de la OMS



Programme de Sécurité des Patients de l'OMS Stratégie 2012-2015

Vision

Chaque patient reçoit des soins de santé sûrs en tout temps et partout dans le monde

Mission

Coordonner, faciliter et accélérer l'amélioration de la sécurité des patients dans le monde entier

Objectifs stratégiques

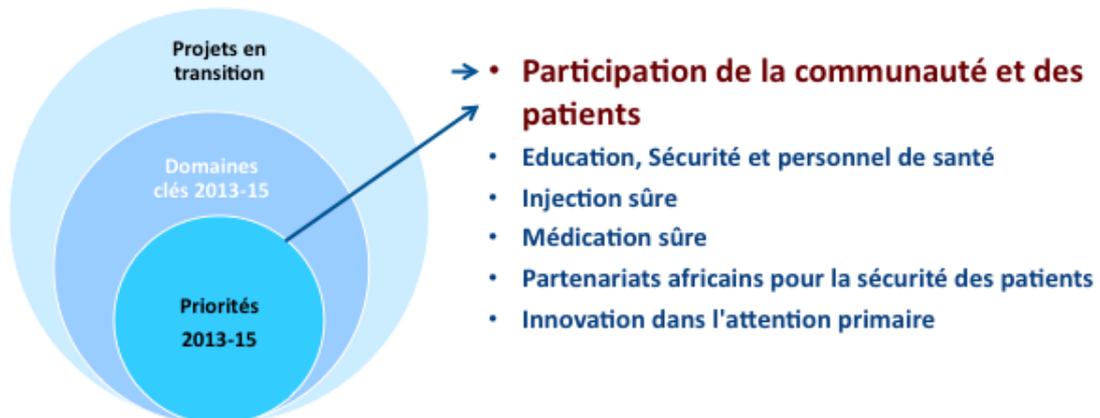
- 1. Assurer le leadership mondial dans la SP**
- 2. Exploiter le savoir, l'expérience et l'innovation afin d'améliorer la SP dans la prestation des soins**
- 3. Travailler avec les systèmes de santé, les ONG, la société civile et la communauté d'experts dans l'effort mondial pour rendre les soins de santé plus sûrs**



Domaines clés SDS 2013 – 2015



Priorités SDS 2013 - 2015



Engager les patients dans les soins de santé: la question n'est pas de savoir si nous devrions le faire, Mais COMMENT?

The Priority Medicines for Europe and the World Project meeting, Brussels, February 2013

Défis



- Augmentation de l'agitation émotionnelle chez les patients / familles (aussi chez les professionnels de santé)
- Augmentation de la peur chez les patients/ familles pour se rendre aux services de santé
- Diminution de la confiance, (personnel, professionnels de la santé, institutions)
- Traumatisme psychologique des personnes impliquées
- Réputation des individus, organisations et même des systèmes.

Source: CPSI, Canada

Opportunités



- Entendre directement les impliqués et comprendre les perspectives des patients / familles
- Identifier les améliorations en matière de qualité/sécurité (ceux qui ont une expérience directe)
- Développer des solutions avec une perspective patient / famille
- Promouvoir la communication et le travail d'équipe qui inclut la participation des patients/famille et autres parties intéressées
- Améliorer/implémenter une culture de sécurité des patients positive, ayant le patient/famille au centre de l'attention

Source: CPSI, Canada

Patients pour la sécurité des patients (PFPS)

- Apporter des changements ayant un impact durable, patients et communauté doivent être au cœur de la mission d'améliorer la sécurité des patients.
- PFPS utilise une approche unique de l'OMS pour engager les patients dans la croyance qu'en partageant des expériences et des connaissances, chaque individu ainsi que l'établissement peuvent apprendre et s'améliorer
- Participation positive et constructive

Valeurs fondamentales PFPS

Collectif
 Franchise
 Honnêteté
 Partenariat de collaboration
 Participation significative
 et "empowerment" (responsabilisation)



Notre travail...



Réseau PFPS

- Renforcement de l'interaction, la communication, la promotion,

Décideurs politiques

- Collaborer avec l'OMS, les organisations nationales et internationales

Institutions académiques

- Créer et partager des connaissances à travers la recherche, l'éducation, la formation

Prestataires des services de santé

- Faciliter la participation des patients dans les hôpitaux et centres de santé

Société Civile, ONGs

- Collaborer avec les ONGs et d'autres organisations

Conclusion and prospects

Ms Béatrice Céretti, President of Le Lien

Mr Alain-Michel Céretti, Founder of Le Lien

Mr Alain-Michel Céretti thanks the representatives of WHO for their presence and the interesting communications that they have presented. He is convinced that all the participants will benefit in their activities in favour of patient safety.

It is remarkable that LE LIEN, which has worked in this area for 17 years, is meeting WHO for the first time today, while they have so many subjects of concern in common.

Many of the participants in this colloquium have, like him, undoubtedly discovered WHO's programme in this regard.

Mr Michel-Alain Céretti notes the parallel in inspiration between WHO's programme and the terminology launched in his day by Dr Bernard Kouchner, then Minister of Health, who was already calling for "health democracy", that is, participation of patients in the healthcare system so that starting from their input, it can change, evolve and adapt to their actual needs.

Taking into account also the fact that, in a country of 65 million inhabitants like France, this health democracy intended by the Healthcare Law of 4 March 2002 needs to be widely publicised in order to be familiar to as many people as possible to be effective. Thus the essential role of the network of associations.

From this point of view, France benefits from a major and dense network of health associations. Mr Alain-Michel Céretti recalls submitting a report to the government on the status of healthcare associations in France in 2004.

In fact, there are more than 7000 associations working in the area of health.

The so-called Kouchner Law on patient rights, at the request of the large healthcare associations, introduced public authorisation of healthcare associations so that patient representation is conducted through authorised associations whose competences, independence and integrity have been validated. In short, that these movements are in fact associations of patients and not associations of healthcare professionals.

Today, only associations authorised at the national level can represent patients with the national healthcare authorities (health insurance, all the national agencies). Associations can represent patients in the region in which they have authorisation, bearing in mind that there are 22 regions in France.

In the future, one of the prospects envisaged is to collaborate at the international level to take advantage of common experience. Unfortunately, there is no well-structured European association movement. This is a deficiency. A common viewpoint, a common voice for European patients measuring the discrepancies from one country to another, especially with regard to real and perceived healthcare safety and respect for rights, is so necessary.

Since 1997, the subject has of course evolved.

The great challenge of tomorrow with regard to patient safety is to obtain “real” mortality and morbidity figures, as well as indicators by unit and not overall indicators.

Mr Michel-Alain Céretti stresses that if he has a serious regret to express now, it is the lack of involvement of physicians on these subjects. Physicians and in particular surgeons are obviously essential participants in healthcare safety. Paradoxically, they feel little involvement with public policies for improvement in patient safety. It is important to include their skills in the initiative. Thus, indicators targeted by unit or speciality could have a direct impact on their image and their reputation, and consequently involve them more.

This colloquium has been an opportunity for exchange and in-depth study of experiences, but has also allowed the discovery of innovative approaches with regard to safety and quality of care.

At the end of this day of joint work, the President of Le Lien, **Ms Béatrice Céretti**, formally emphasised the association’s support for the objectives of WHO’s programme “Patients for Patient Safety Global Network”. A close collaboration is thus being undertaken between LE LIEN and WHO to support the initiatives of patients and their families.

Ms Béatrice Céretti and Mr Alain-Michel Céretti concluded with *“their very great satisfaction in seeing the societal and humanist commitment of Le Lien acquire an international dimension and recognition that will allow it to further expand its influence in the service of patients in France and beyond.”*

Mr Hervé Féron, Deputy from Meurthe et Moselle, concluded *“that having hosted this colloquium at the National Assembly was for him a great satisfaction, seeing the foundations for an international collaboration arise in this very place on a subject, the improvement in the quality and safety of healthcare, that has motivated him for many years.”*

