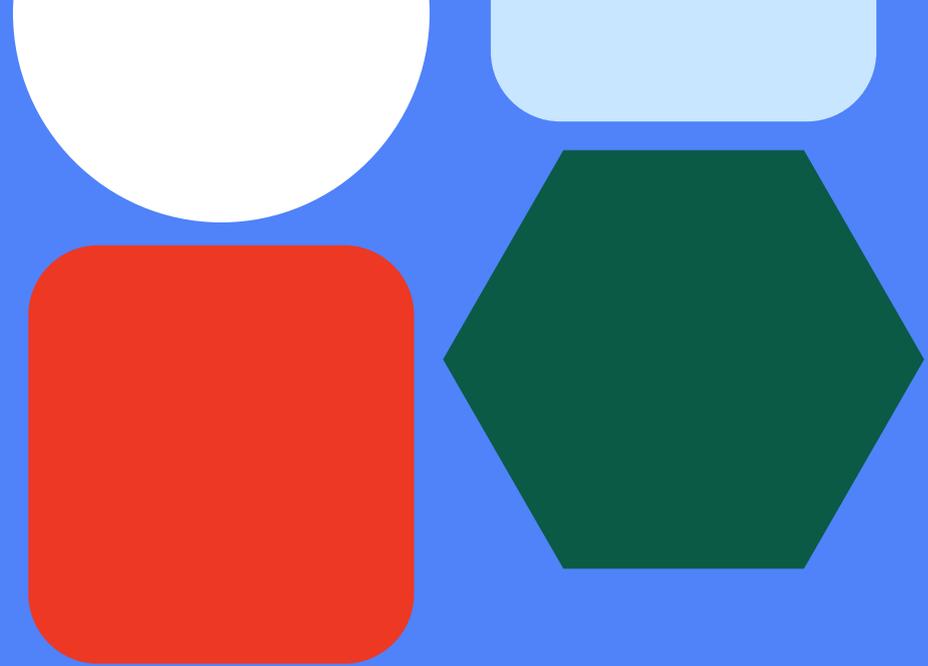




European Society of  
Anaesthesiology and  
Intensive Care



# Helsinki Declaration

## on Patient Safety in Anaesthesiology

# Helsinki Declaration Overview

## Background



**~230 million**  
patients

**WORLDWIDE**  
undergo anaesthesia  
for major surgery  
**every year**



**7 million**  
patients

develop severe  
complications associated  
with these surgical  
procedures



**1 million**  
200K in Europe  
patients

**DIE**

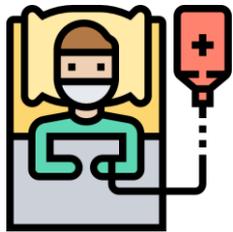
**Anaesthesiology is the key specialty in medicine to take up responsibility for improving Patient Safety in Europe.**

Anaesthesiology shares responsibility for quality and safety in Anaesthesia, Intensive Care, Emergency Medicine and Pain Medicine.

# Helsinki Declaration Overview

**Patient safety** has three components: a set of guiding principles, a body of knowledge and a collection of tools.

Safety **can be improved by analysing errors and critical incidents**, rather than pretending they have not happened; and humans, machines and equipment are all part of a system, the component parts of which interact to make the system safe or unsafe.



## Issue:

**The potential for harm has increased.**

Healthcare professionals cannot continue to manage the risks alone and without over control.



## Solution:

The tools include:

- ✓ **critical incident reporting**
- ✓ **checklists**
- ✓ **safe system design**
- ✓ **communication protocols**
- ✓ **systematic analysis of risks.**

# Helsinki Declaration Overview



**The leaders of societies representing the medical speciality of anaesthesiology agreed Helsinki Declaration on Patient Safety in Anaesthesiology on 13 June 2010:**

1

Patients have a right to expect to be safe and protected from harm during their medical care.

2

Patients have an important role to play in their safe care.

3

Healthcare founders have a right to expect that anaesthesia care will be delivered safely.

4

Education has a key role to play in improving patient safety.

5

Anaesthesiology has been a key speciality in medicine leading the development of patient safety.

6

Human factors play a large part in the delivery of safe care to patients.

7

No ethical, legal or regulatory requirement should reduce or eliminate any of the protections for safe care set forth in this Declaration.

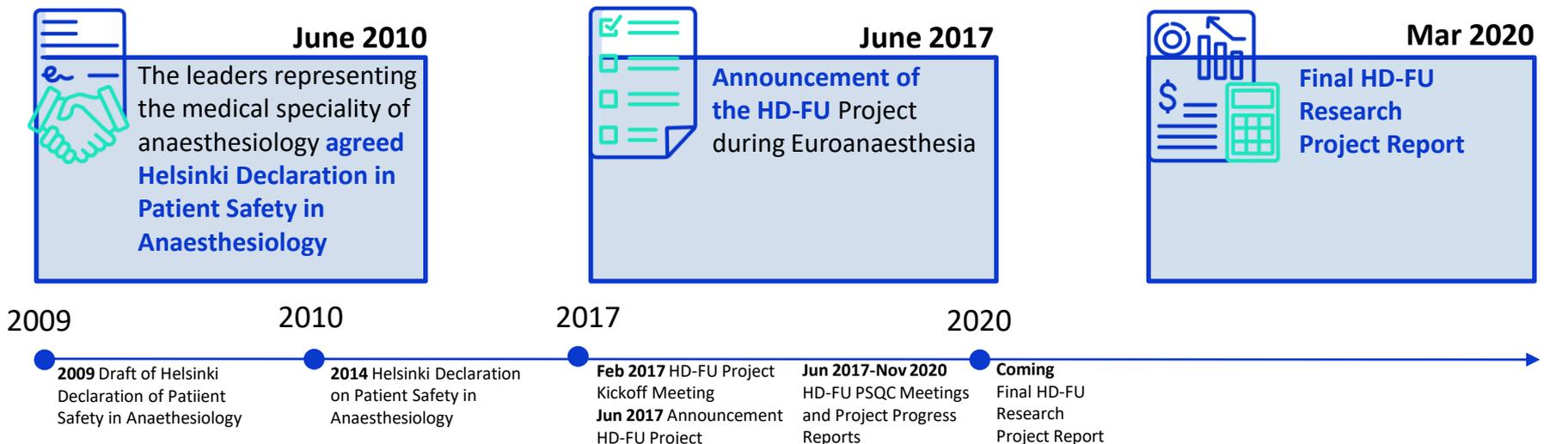
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Our partners in industry have an important role to play in developing, manufacturing and supplying safe drugs and equipment for our patients' care.

# Roadmap for implementation of Helsinki Declaration into clinical practice

The purpose of this project is to **improve patient safety** in line with the HD. Project goals to achieve this purpose:

1. to evaluate adoption of the HD in Europe, to identify variations and barriers in the implementation process
2. to develop instruments for better implementation by the use of multi-method approaches.



# European Survey

## Patient safety and the role of the Helsinki Declaration on Patient Safety in Anaesthesiology

The **Helsinki Declaration on Patient Safety was launched in 2010** by the European Society of Anaesthesiology and the European Board of Anaesthesiology. It is perceived as a force for good, a standardization framework and a catalyst for change.

**The HD-FU Project will try and establish how widely its vision and standards have been adopted.**

### Participants



Members of the European Society of Anaesthesiology who responded to an invitation to take part by electronic mail from **38 countries** within Europe.

### Main outcome measures



Responses from **a 16-item online survey** to explore each member anaesthesiologist's understanding of the Declaration and compliance with its standards.

# Numerical Demography - Members of Survey



**77%**  
Qualified Anaesthesiologists

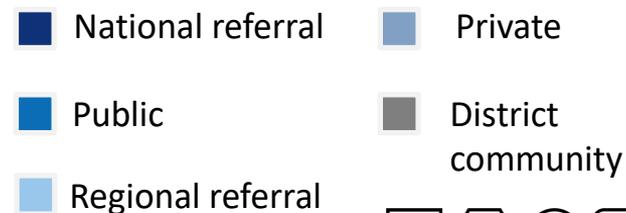
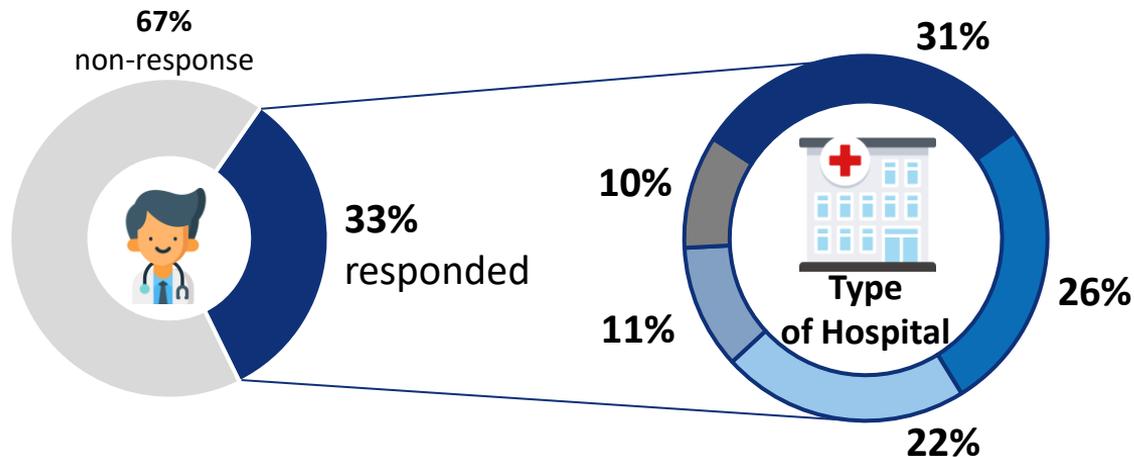
**14%**  
Trainee Anaesthesiologists

**9%**  
Clinical directors

The invitation to take part in the survey was sent to **4764 members** of the ESA.

**1589 members** participated in the survey.

**Response rate (RR)** varied by country  
Median [IQR] RR = 20.5% [11.7 to 37.0], with a range of 5.2 to 100%.



# Summary of respondents' perceptions of influences on patient safety in European anaesthesiology

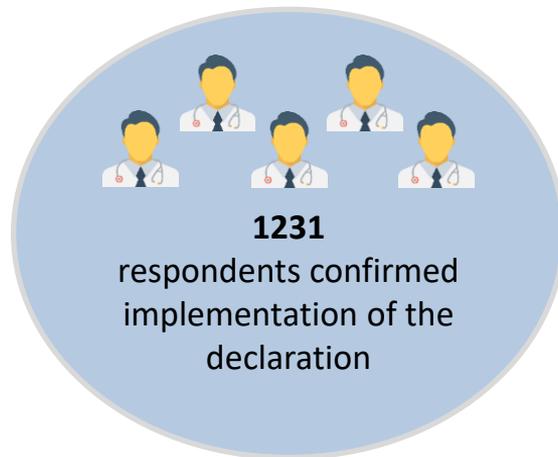
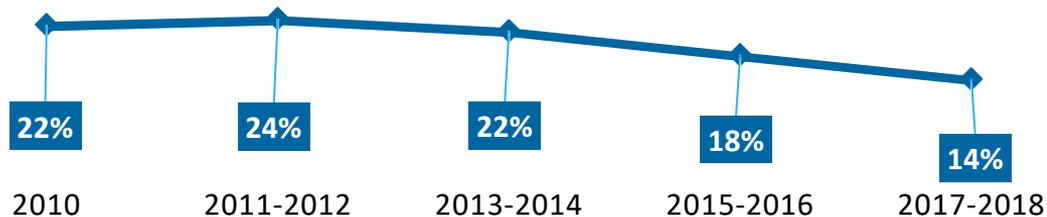
Positive	Negative
Guidelines and protocols	<b>Financial austerity</b>
Monitoring	<b>Medical workforce migration</b>
Vigilance	<b>Older, sicker patients</b>
Equipment and drugs	<b>Production pressure</b>
Pre-operative assessment	<b>Lack of time to talk about safety and quality</b>
Education on safety culture	<b>Lack of trust to enable sharing of incidents</b>
Keeping up to date	
Colleagues who have worked overseas	
Good relationship with government	
Regional networks	

**Intensifying workload, more challenging patients, suboptimal pre-operative preparation** are commonly cited **areas of change**.

The vast majority of respondents highlighted the critical nature of safety culture, human factors and training systems in maintaining patient safety. **Culture plays a key role in adoption of safety tools and practices.**

# Awareness and perceptions of impact of the Declaration

Number of ESA members whose hospitals have already implemented the Helsinki Declaration on Patient Safety in Anaesthesiology in 2010-2018



Has your national anaesthesiology society signed up to the Helsinki Declaration on Patient Safety in Anaesthesiology? (n=1530)



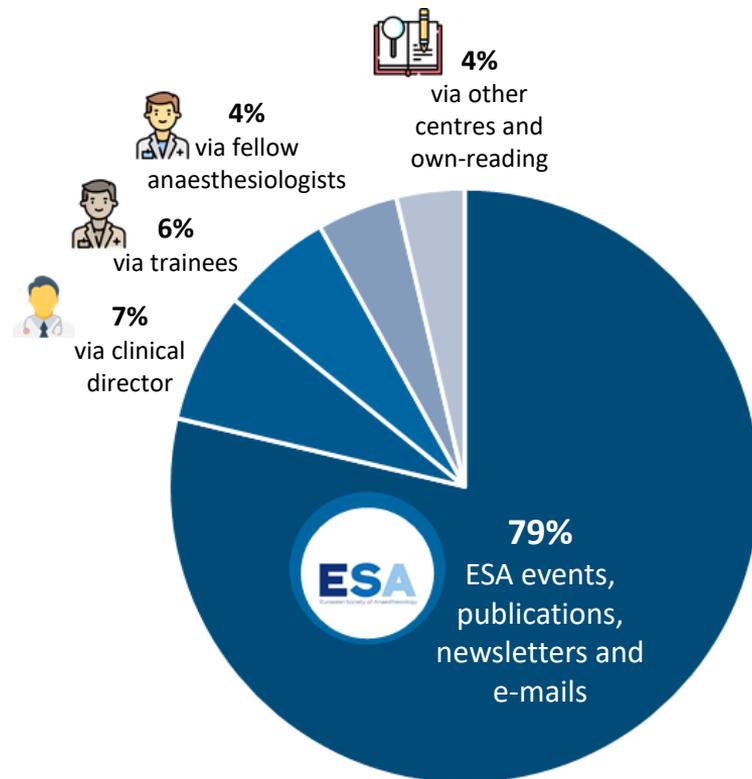
Has the Helsinki Declaration on Patient Safety in Anaesthesiology improved patient safety in your hospital? (n=1580)



# Awareness and perceptions of impact of the Declaration

**1231 (78%)** of participated experts confirmed that their hospitals have already begun to **implement the Helsinki Declaration on Patient Safety in Anaesthesiology.**

Survey summarizes that **79%** (out of 1450) of responded representatives know about Helsinki Declaration on Patient Safety in Anaesthesiology through ESA sources.



# Prevalence of specific measures for promoting safety

## Monitoring standards for peri-operative anaesthesia care (out of 1582 respondents)



**99.6%**  
Pulse oximetry



**99.4%**  
Blood pressure



**98.1%**  
ECG



**96%**  
Capnography

## Additional monitoring modalities (out of 709 respondents)

Temperature **89.7%**

Neuromuscular **87.4%**

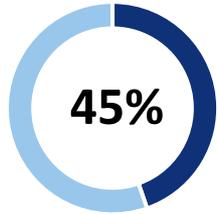
Bispectral edge **86,5%**

EEG **69.8%**

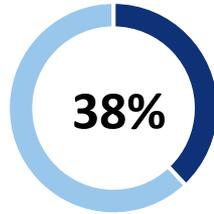
# Prevalence of specific measures for promoting safety

## Sedation standards used by hospitals (out of 1546 respondents)

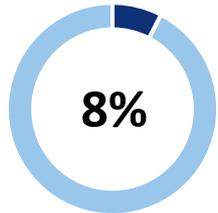
### Local policies



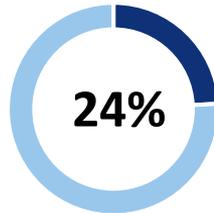
### National guidelines



### Regional policies



### Unsure



## Protocols and guidelines used by hospitals (out of 1582 respondents)\*

Pre-operative assessment/ preparation	93.4%
Difficult/failed intubation	88.8%
Checking equipment and drugs	87.9%
Syringe labelling	82.6%
Post-operative care including pain relief	77.9%
Massive hemorrhage	75%
Anaphylaxis	
Local anesthetic toxicity	
Malignant hyperpyrexia	
Infection Control	

\*The question was based on principal requirements of Helsinki Declaration on Patient Safety in Anaesthesiology

# Prevalence of specific measures for promoting safety



Does your hospital use the WHO Safe Surgery Checklist or a modified version before each procedure?

78% yes

6% no

16% unsure

**78% of respondents** confirmed that their hospitals follow WHO Safe Surgery Checklist. **6% of respondents** suggest that they never used checklists.

**A quarter of respondents** is unsure or does not use reporting systems. There is a significant **range for improvement** that is equal to **23%**.



Does your hospital use critical incident reporting systems?

77% yes

14% no

9% unsure

**Only 56% of respondents** report on patient morbidity and mortality and collect data each year.



Does your hospital collect data to produce an annual report on patient morbidity and mortality?

56% yes

16% no

28% unsure

# Prevalence of specific measures for promoting safety



Does your hospital contribute towards national audits of safe practice in anaesthesiology?'

37% yes

27% no

36% unsure

**63% of respondents** still do not contribute towards national audits of safe practice.

**Only 37% of respondents** report annually measures used to advance in patient safety.



Does your hospital produce an annual report of measures used to improve patient safety in your hospital?

37% yes

27% no

36% unsure

# What will be next? Suggestions for further development of the Helsinki Declaration on Patient Safety in Anaesthesiology



Structures for safety education for anaesthesiologists



Promote a 'no blame' culture: reporting and open discussion

Greater Patient involvement in the promotion of safe practice



Preoperative assessment: clinical, humanitarian and economic case



Regional networks to share practice and resources

Created by Adrien Coquet from Noun Project

Created by Gan Khoo Lay from Noun Project

Created by gilbert bages from Noun Project



Together for  
patient safety  
and health