Patients for Patient Safety News

August 2008

Welcome to the August edition of PFPS News! So much has been happening and this month's edition includes reflections from Champions that presented at HEPS 2008, news from the recent Safe Surgery Saves Lives Launch, along with recent activities in Croatia, Lebanon and much more!

CHAMPION ACTIVITIES around the world!

International Conference in Croatia on Stigma and Patient Safety Activities for Mentally Ill People.

- Ema N. Gruber, Happy Family NGO and Patient Safety Champion, Croatia

On June 16 in Popovača, Croatia, The Society for Improvement of Mental Health and Quality of life of the Mentally ill and their Families "Happy family", together with the Neuropsychiatry Hospital "Dr.I.Barbot" Popovača and under the auspice of the Ministry of Health and Social Services Croatia, organized an International conference "Stigma of mental illness in Croatia and Happy family activities for Patient Safety in mental health".

Ema Gruber, Psychiatrist and Patients for Patient Safety Champion was President of the organization board and runs the Happy family NGO. The conference was supervised by the Croatian Medical Association and Association of Medical Nurses. There were 135 participants; medical doctors, nurses, social workers, psychologists, patients, families, NGO members, city counsels and some politicians. PFPS Champions Ema Gruber and Ahmed Novo participated, along with Valerija Stamenic who attended the EURO PFPS Workshop in Dublin. The Conference was a good example of NGO's, Ministries of Health and WHO, working together in two countries.

The conference started with a hospital tour organized for participants to see the Neuropsychiatry Hospital in Popovača, where 600 mentally ill people on different wards are treated as inpatients and 2000 as outpatients. This was followed by a series of lectures which included presentations from Doctors, Ministry Representatives, Social Services, NGO's and other healthcare workers from Croatia, Bosnia-in Herzegovina and Israel, speaking on a range of issues around quality, safety, attitudes and the stigma of mental illness, rehabilitation and work with patients families – including a look at the work done by the Happy Family NGO over the past year - and later there was an exhibition of patients work and folklore dance. After the lectures, the IV Annual meeting of Happy Family NGO and the book of the abstract from the conference was presented along with the NGO book "How to live and treat safely when you have mental illness". Both books can be downloaded from the link www.sretnaobitelj.odlican.net under the Publication section. This was the first time in Croatia that a similar conference was held, speaking publicly about patient safety in the mental health field, gathering experts, politicians and mentally ill and their families. Photos from the conference can be found at the following link; http://sretnaobitelj.odlican.net/index.php?iz=1-108-0.

What's inside?

- HEPS Conference 2008
- Slovenia activities
- World Alliance Safe Surgery Launch and Education meeting
- News from EMRO

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Champions run Workshop Session with Medical Students

- Katja Srpan, pharmacy student, Project Healthcare Team, Slovenia

This April the 10th Healthcare team meeting was held in Slovenia. This is a project that ties up students from different healthcare fields, such as medicine, pharmacy, nursing and physiotherapy. The main goal of our project is to teach them the importance of collaboration between all health service workers, not only in complementing their professional skills but also in communication between them. The event usually consists of lectures and workshops dedicated to a certain theme (the last one was multiple sclerosis). A special day was added this year dedicated to medical errors. Especially those made because of lack of communication between specific areas. This is a common problem, which does not get enough attention.

On the first day of the event we had a great honour to listen to a prime lecture given by Mrs. Vladimira Leskovec, MSc, PhD and Mrs. Vlasta Kaloper, Patients for Patient Safety Champions, with the title ˝Patient Safety and the Importance of Communication in Healthcare˝. They showed us that no one is all-knowing, and that there always exists a need for cooperation in order to achieve one goal that we all have in common – the patient's safety and his recovery. During the day we heard some wonderful suggestions of how to reach that.

Mistakes caused by lack of communication and their terrible consequences were also shown in a movie we watched that day. Relatives who lost their family members because of such mistakes shared their stories.

Later we had a workshop, where students of medicine, pharmacy and nursing cooperated together. Our solutions and conclusions were expressed on several posters. We realized that the problem is not only in differences between professions. It is also present in each individual, who has to alter his way of thinking. For all of us it was a useful experience. The goal of such project is only in what its participants learn and carry with them to their future careers. We sincerely hope that such goal has been achieved.

Launch of the Argentinean Patient-Doctor Collaboration Network

Apologies this article was in the June Newsletter but contained a few errors which have been corrected below;

Claudia Cattivera, a Patients for Patient Safety Champion from Argentina, and her physician (Dr. Agustín Ciapponi) have recently coordinated the creation a patient-doctor network. Claudia is the Director of www.PacientesOnline.org, a patient-centred website that receives of 20,000 visits each month.

At these initial stages, the founding committee of RAMPA (Argentinean Patient-Doctor Collaboration Network) is composed of two doctors and three patients. In line with a collaborative patient-doctor philosophy, RAMPA provides common ground for Argentinean patients and physicians at different national and international level of decision in health. The mission of the organization is to promote the quality of health services, by means of common interest actions to patient and doctors and other health professionals. Hence, the RAMPA founding committee has already developed 11 lines of action, including the enforcement of the rights of patients and health professionals, participation in health quality improvement programs, and promote patient safety research. RAMPA's activities will be executed in coordination with 20 patient and doctor associates.

For further information, please refer to Claudia Cattivera, claucatt@gmail.com

'Being Open' Training for PFPS Champions in England and Wales

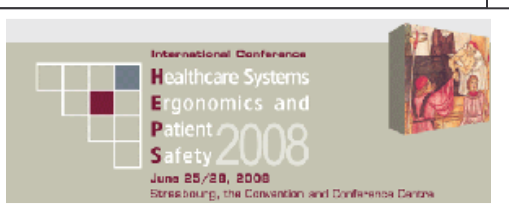
- Anna Allford, Project Manager, Patients for Patient Safety, England and Wales

Ten of the Patients for Patient Safety Champions in England and Wales attended a training session, at the offices of the NHS National Patient Safety Agency (NPSA) on 14th July, designed to provide them with an understanding of the policy **Being Open - communicating patient safety incidents with patients and their carers.** The NPSA's Being Open policy is part of a national drive to help healthcare staff with this difficult task. The Being Open policy advises healthcare staff to apologise to patients, their families or carers if a mistake or error is made that leads to moderate or severe harm or death, explain clearly what went wrong and what will be done to stop the problem happening again. This topic had been identified as an area for Champions to be able to add value to by utilising their personal experiences and patient perspective, at their Induction Workshop earlier this year. More information about 'Being Open' can be found on the website of the NPSA: www.npsa.nhs.uk

The training session generated much discussion and also prepared Champions for how to present their role to NHS staff and focus on the importance of Being Open when things go wrong for patients. Feedback was extremely positive and a future Masterclass in the subject may be offered later this year for all Champions in England and Wales. One participant said *"…very informative, interactive and worthwhile. I would recommend it to others."*

The presentations from: Suzette Woodward, Director of Patient Safety Strategy & Nursing Lead for Patient Safety at NPSA; Peter Walsh, Chief Executive of AvMA; and Anna Allford, Project Manager - Patients for Patient Safety, AvMA, are available to view from the AvMA website: www.avma.org.uk

Patient Champions involved at HEPS 2008, Strasbourg (Healthcare Systems, Ergonomics and Patient Safety)



Jolanta Bilinska, Patients for Patient Safety Champion, Poland

Representatives from different branches of medicine, psychologists, architects, IT specialists, attempted to find the best solutions in promoting safety of patients undergoing treatment at the conference. Real patients had the opportunity to express their opinions, which made conference participants reflect on cooperation between medical staff and patients in the treatment process. It was very important for the Patients for Patient Safety Champions, of the PFPS programme, World Alliance for Patient Safety, to be able to share their opinions, as well as their experiences in getting patients involved in the treatment process. Examples of malpractices, medical errors, lack of external control of medical equipment involving the so-called human factor, were an important element of the meeting. Each session began by discussing stories of patients and a plan to introduce changes to eliminate errors. I enjoyed Christine Perera's presentation, who has suffered so much due to wrong diagnosis / treatment, but believes patients' stories help physicians and nurses to be more sensitive to potential tragedies. The thought of Mahatma Gandhi - taking whatever we want to change, in our hands, kept haunting me long after the session closed. It was the 2nd time I met Evangelina from Mexico who travelled to HEPS with her son – during her presentation many of the participants eyes were filled with tears. This was also the first time I was able to meet Eva and Katrine, who prepared very professional presentations and a film presenting short stories of medical errors.

I presented the story of infected infants in a Lodz hospital, which is known to PFPS Champions. For six years the case had been pending in court before the mothers of the infants who died in 2002 won. Since that time all neonatal wards in Poland have been under special control. The mothers have been in e-mail contact and they provide mothers who have any doubts about safe delivery with respective counselling. Owing to the conference our voice, the voice of patients, could be heard again. Talks behind the scenes made me realize that a lot of physicians, participants of the conference also found the problem important and promised to improve communication at the physician – patient level.

More reflections from the conference can be found below;

Eva Simonson, Patients for Patient Safety Champion, Denmark

"…I found that the first 15 minutes in the beginning on each session was a GREAT idea…"

Katarina Stanisic, Patients for Patient Safety Champion, Canada

"…Sharing our lived experiences with professionals from around the world delivered three key messages: 1) behind the statistics are real people, with names, with faces and with loved ones-these stories are humbling and act as an inspiration and call to action; 2) Patients and family members want to partner and can significantly contribute to the initiatives underway, worldwide, to improve patient safety; 3) We are all patients and family members. Although health care professionals come to the table with their professional 'hats' on, we are all patients and family members of our respective health care systems…"

Evangelina Vasquez, Patients for Patient Safety Champion, Mexico

For some champions it was our first meeting, and for others a reunion – with those I had got to know in London in 2005, we observed a growth in experience that we were able to share with each other. I met many patients with great cultural differences, but learnt that we share the same concerns, hopes and objectives. I believe this experience will help me to offer advice about how to confront the difficulties. I was able to understand many things that have happened to me during my work in my own country, through the work of other patients around the world, and I believe that sharing old and new experiences from my work as a Mexican patient will have helped them in some way.

The rest of the congress participants seemed very moved by our presentations, and there was a lot of interest in supporting us to prevent adverse events happening in the future – I also shared the story of another Mexican woman, called Ruth, who committed suicide after loosing her baby and womb due to a bad medical error and the denial of this error. These are experiences that allow others to realize the importance of this problem. I also loved the fact that patients were able to gain access to this type of congress – to be able to learn more about patient safety, and in particular the new theories to understand adverse events were very interesting.

Sara Yaron, Patients for Patient Safety Champion, Israel

I too think it was a great success being represented at the HEPS2008, as PFPS champions. The wonderment it left upon the organizers, and the participants, IS UNFORGETTABLE. It was seen, felt and heard. As about my personal insight: I deeply believe that most of the professionals were influenced by our presentations and talks, and it'll in some way, be reflected on their professional work, while being in front their patients. They were deeply moved by our expressed grief and suffering, in a direct way, and some of them expressed it frankly. With modesty, I believe that some of them, in a way, will not stay the same doctors, as they were before. I have got some requests from the audience, to hear more about my work in mediation in malpractice cases. I do think that there is a lot of work to do!!

Jolanta Bilinska, Patients for Patient Safety Champion, Poland

We also had the chance to watch a film made by an Australian physician, who admitted making a medical error, however, he managed to correct it when the patient was still lying anaesthetized on the operating table. The physician confused the left cerebral hemisphere with the right hemisphere of the patient undergoing operation. This controversial film divided even us, PFPS Champions, into two groups. I considered the film to be a very good educational material for medical staff, which presented, a bit ironically, how little time medical staff devoted to patients. It showed that medical staff did not talk to patients, treated them instrumentally calling them for example "D3 room patient", etc., that operations were conducted at random and there were a lot of patient identification mistakes. But some of my colleagues were of the opinion that the film stripped patients of their dignity, that even a small change in a name may have irrevocable effects, e.g. operation on a wrong patient may not be dealt with the way it was presented in the film. I strongly believe that the more films are presented, the more often the subject of wrong communication is dealt with in discussions at hospitals, the more often we will think about how to change it. We had a great discussion.

Patient-Centred Care, Ethics and the Vulnerable Populations

- Barbara Farlow, Patients for Patient Safety Champion, Canada

It has been three years since the death of my 80 day old daughter, and almost two years since I became a Patients for Patient Safety Champion, Canada. My advocacy relates to improving patient-centered care and ethical treatment for vulnerable citizens. My daughter Annie died within 24 hours arrival of a world class children's hospital. A "Do Not Resuscitate" order was placed without informed consent during that time and there are many concerns about missing records and large withdrawals of narcotics during the final hours of her life. Annie had a genetic condition related to disabilities. I have come to understand that hospital policies, health care laws and basic human rights can be superseded by priority-setting policies. In Canada, the vulnerable have rights in theory, but not in practice. I appreciate that the demographics of our population create very difficult challenges now and especially in the times to come. I hope that by sharing our tragic experience, I might influence policies and protocols to ensure that patients receive compassionate medical care. I believe that priority-setting strategies must be developed with input from the public and must be transparent and fair to everyone.

Last month, the Canadian Paediatric Journal *Paediatrics and Child Health* published my essay "The decision to accept disability: One Family's Perspective" and I was very grateful for the recent opportunity to deliver the first Annual Sue Macrae Lecture on Ethics and Patient-Centered Care at the University of Toronto's Joint Centre for Bioethics. Owing to some fabulous support from the patient safety, disability and ethics community, I am told that the lecture set an attendance record. The talk is archived at http://epresence.ehealthinnovation.org/ under archived webcast events and then click on 'JCB endowed Lectures'.

I am very interested to connect with other champions who share my concerns about patient-safety issues of this nature.
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PFPS Workshop in Chicago

- Mitch Dvorak, Executive Director of Consumers Advancing Patient Safety (CAPS)

Over 90 people participated in the Workshop on Consumer Engagement in Selected Patient Safety Topics in Chicago June 19-21, 2008. Half consumers/patients and half healthcare professionals, including physicians, nurses, a pharmacist, rehab services professionals and representatives from quality improvement organizations, state and federal government agencies and others. Most of the participants were from the Chicago area, with about 10 participants from Australia, Canada, England, Ireland and several other states in America. This latter group were invited to bring some experienced voices from patients, leaders and advocates for patient safety.

The meeting was hosted by Northwestern Memorial Hospital (NMH) and designed in partnership with leaders from two Chicago based international organizations, Partnership for Patient Safety (p4ps) and Consumers Advancing Patient Safety (CAPS), as well as the World Alliance for Patient Safety's Patients for Patient Safety program.

The group brought a wealth of experience to the workshop. Most of the consumer/patient participants had been personally affected by medical error. Several of the participants described the death of a parent or a child due to preventable error, and many described other serious harm including infection, permanent injury to their own or a loved one's health, multiple hospitalizations, and cost and psychological trauma associated with these events.

In his remarks, Dr. Chuck Watts, senior vice president and chief medical officer at Northwestern Memorial Hospital, discussed the success NMH has had in dramatically reducing the risk of adverse events in our hospital. He also frankly said some avoidable adverse events still happen, even in their hospital, and they are committed to eliminate them. He described their commitment to lead locally and nationally in the development of innovations and creative partnerships with patients to eliminate error.

The purpose of the workshop was to design bold aims and practical action plans which could be implemented in Chicago or elsewhere to make patient care safer. Every participant contributed to each of six workgroup topics and produced action plans and proposed evaluation of the plans, as well as discussion of how these actions will benefit Chicago, barriers to implementation, and suggestions for priorities and resources.

The workshop is a first-ever event in several ways. It is the first time that providers and patients have been assembled to focus on regional patient safety issues, and it is the first time that a collaborative workshop has been designed to produce actionable implementation plans. Partners WHO World Alliance for Patient Safety, CAPS and p4ps have conducted workshops in other global regions, usually on a national level, and usually designed to develop consensus on important broad patient safety themes. This workshop created an actionable toolkit which can be used locally and beyond.

Continued on page 6…

The six discussion topics included:

- How to facilitate patient reporting of patient safety events and opportunities;
- How to integrate patient/family engagement in policy and process development;
- Advancing patient/family involvement in their own care;
- Techniques for effective patient/physician (clinician) communication;
- How patients can partner with the care team to prevent error; and
- The role of patients and clinicians in working through error when it does happen, through disclosure, investigation and root cause analysis, long term learning and emotional support.

The workshop was funded by grants from the U.S. Agency for Healthcare Research and Quality and the local Otho S.A. Sprague Memorial Institute.

Proceedings of the workshop will be published widely in professional journals and consumer publications, and will be shared with other groups engaged in patient safety improvement, including the Chicago Patient Safety Forum, Illinois Hospital Association, Illinois Department of Public Health, and others which assisted in planning the program.

Planned long term follow-up includes further development of the action plans for implementation at NMH and other local healthcare organizations, and exploring the use of the action plans by the Chicago Patient Safety Forum and its members. The workshop produced remarkable, rich, creative action plans, and a tremendous sense of hope and healing among the participants.

Key leaders of the program included:

Marty Hatlie, president of p4ps;
Dan Ford, an executive recruiter and international advocate for patient safety;
Sue Sheridan, CAPS president and external lead of Patients for Patient Safety; Mitch Dvorak, executive director of CAPS
Helen Hughes, World Health Organization World Alliance for Patient Safety; and
Cindy Barnard and Gary Noskin of NMH.

News from EMRO

The 1st National Symposium of Patient Safety "Patient Safety …Toward building a Safer Health Care System"

Nasr Ali Ahmed, Patients for Patient Safety Champion, Yemen

Toward increasing the public awareness among the stakeholders who represent the health leadership at MOH ,different health care settings and health care providers as well ,under the auspice of HE the minister of public health & Population the 1st national symposium for Patient Safety was held in Sana`a , Yemen on 29.June.2008 in collaboration with WHO-EMRO. The symposium also has aimed to build a national consensus and advocacy in regards to the Safe practices and to strengthen the organizational responsibility in identifying Patient Safety within its structural and technical policies, also the healthcare personnel responsibility in delivering a safe care considering the magnitude of the AEs and medical errors that happen every day inside the healthcare settings according to many national and international resources and studies.

The message of that symposium was to call all health leaders, national associations, NGOs, educational institutions and healthcare providers to act seriously enough to ensure the safety of care delivered to patients to maintain and build the human life and not to be a source of their harm or death. Patients were part of that symposium and had the opportunity to speak in front of the audience about their concerns. The deputy minister has confirmed the support of MOH to patient safety as a priority and that patient safety is also an opportunity for health care system improvement. Also, he emphasized on activating the medical council at MOH level. The Hospitals directors who have attended the symposium have agreed on forming the patient safety committees in the hospitals and to facilitate the functions of these committees that will work very close to the patients and their families.

Working recently with WHO-EMRO and Dr. Ross Wilson –an international expert- in preparing to develop a national plan for patient safety in which different items regarding PS and patient involvement will be addressed according to the findings of the AEs study that was conducted earlier with WHO-EMRO support.

Patient Safety Culture - Safety Project, Phase 1

Muhamad-Ali Hamandi, Patients for Patient Safety Champion, Lebanon

As a medical professional I have been involved in a joint on-going project in Lebanon between the World Health Organization and Syndicate of Private Hospitals in Lebanon. The syndicate of Private Hospitals has strived to improve the knowledge base of hospitals and has run several workshops and training sessions on several issues related to quality. The need to investigate the culture of patient safety in Lebanese hospitals was identified, to date there is no one study that describes the magnitude of the problem in Lebanon. The Syndicate of Hospitals has expressed the need to train hospitals on patient safety but it lacks data on priorities to be addressed.

Below is a summary of the research that was carried out:

1. Methodology:

Assessment of the situation was done by collecting data about the culture of patients' safety from Lebanese Hospitals. Data collected consists of two major parts: Independent and dependent variables.

I. Independent variables include:
   1. Information about nurses: **Educational qualifications, Position. Gender, Work area, Age, Experience**
   2. Information about the hospital: **Region, Bed size of hospital, Ownership - (private (for profit), University, Non-profit and Governmental), Quality management system presence and type**

II. Dependent variables include:
Teamwork, Culture of blame, Statistical analysis of errors, No. of events reported, Training Presence of policies, Presence of safety officer, Patient safety grade

2. Data collection:

The self administered questionnaire (Annex 1) was put in Arabic and tested for validity and reliability. Three surveyors were trained to help in data collection. The Syndicate of Hospitals sent a letter to all hospitals explaining about the project and asking for their cooperation in data collection A questionnaire was addressed to nurses in all hospitals in Lebanon inquiring about patients' safety culture. The sample size is 12% of the number of beds yielding a total sample of 1,000. The total number of questionnaires collected was 1,074.

a. Results:

Safety Culture Items	Score %
Team work	62%
My opinion is taken into account whenever a decision needs to be taken in my unit	56%
The quality and outcome of patient's care when the team discusses his case	74%
The nurses cannot request the physician to review his order *(negative question)*	39%
My co-workers help me when I get work overload	71%
My manager encourage me to cooperate with the team	
Non-punitive approach / blame	32%
There exists a hospital policy that prevents punishing people who inform about their mistakes	31%
When an error is discovered, the team tries to discover the responsible who did it *(negative question)*	6%
The hospital rewards individuals who report errors with patients	20%
When an error is discovered, the team tries to discover the reason for the mistake	68%
Staff blame others when a mistake is discovered *(negative question)*	37%
Transparency: I am ready to write a report to my superiors when I discover a patient related error	65%
Prevention: Most patient related errors could be prevented	58%
Training	62%
New employees are oriented on how to prevent errors	63%

New employees are oriented on how to report errors	62%
Hospital Policy: There exists a hospital policy to report patient related errors	62%
Patient Participation: The patient participate in plan of care and treatment	32%
Data Collection and analysis:	61%
I participate in data collection on patient related errors	51%
I know about all mistakes that happen in my unit	61%
All errors that occur in my unit are discussed to prevent their recurrence in the future	74%
Overall patient culture score	**53%**

b. Discussion:

The safety culture score is low (53%). The main factors affecting this score are: culture of blame, punitive approach to error reporting (32%), participation of patient in decision making regarding his plan of care (32%). On the other hand, Lebanese accreditation system has improved some aspects of healthcare quality. This is primarily shown in orienting and educating staff (62%). In addition, most hospitals reported having an incident report form. In contrast, more than 90% of nurses reported less than 5 errors in the last year. If this result is compared to the probable low score of culture of blame, we conclude that staff are reluctant to report errors. This possible under reporting hinders analysis of the root cause of problems encountered. Hence, corrective/preventive actions are not identified to prevent recurrence. Moreover, a false sense of security is felt by hospital management.

The safety culture score improves with age and position of nursing staff. This suggests that experience is a major decisive factor in the culture of safety. This same trend persists with position because senior positions are occupied by older staff. Furthermore, errors are discussed but staff do not participate fully in data collection and analysis. Most data are collected and analyzed by senior staff and junior ones play a passive role in this respect.

Physicians play a major role in many aspects of patients' safety culture namely: review of order, patient's participation and team work. However, the attitudes of physicians were not addressed fully in this study. Moreover, the conversation that takes place between the physician and the patient or the family is not always witnessed by nurses; hence, this matter needs further investigation.

It is worth noting that bed size, hospital location, educational qualifications, gender, and work area did not affect the safety culture score.

3. Future Plan: (Phase 2)

- **Planning a presentation session to the board of administration of the Syndicate of Hospitals in Lebanon to:**
  - ✓ Explain results
  - ✓ Recommend future plans
  - ✓ Identify improvement areas
  - ✓ Identify additional plans that improve the situation

- **Educate nurse leaders to address these main themes:**
  - ✓ Presentation of results
  - ✓ Teamwork
  - ✓ Non-punitive approach to errors
  - ✓ Root cause analysis
  - ✓ The workshop will stress on the root cause analysis and non-punitive approach
- **Share these results with patients' safety societies to maximize benefits.**

If you want to find out more about Muhamad-Ali Hamandi's research you can contact him at: mhamandi@hotmail.com

World Alliance for Patient Safety

SAFE SURGERY SAVES LIVES LAUNCH

The World Health Organization's Safe Surgery Saves Lives initiative was formally launched at a global event hosted by Dr Mirta Roses Periago, WHO Regional Director for the Americas, on 25th June. The event was attended by Ministers of Health, world leaders in surgery, anaesthesiology and nursing, and Dr. Atul Gawande, the lead for this WHO initiative to reduce deaths and complications in surgery globally.

Bill Wright, Patients for Patient Safety Champion, USA

It was my honour to witness this important ceremony with more than 300 participants, representing more than 30 national ministries,35 hospitals and 65 medical societies, medical colleges and professional associations. Several major **Patient Safety Organizations** were represented by our Patients for Patient Safety Lead, Susan Sheridan, who spoke enthusiastically about the advocacy and support of patients across the world.

Dr. Carolyn Clancy, Director of the U.S. Agency for Healthcare Research and Quality (AHRQ), addressed her eloquent comments on role of governments in acting aggressively in their support of the goals and programs of WHO's recommendations. After Dr. Clancy's remarks, a letter of endorsement from the ailing keynote speaker, U. S. Senator Edward M. Kennedy, was read by his Sr. Advisor, Ms. Kavita Patel.

Sir Liam Donaldson, Chair of the World Alliance, challenged leaders of global healthcare systems to adopt universally the critical concept of the **Surgical Safety Checklist.** The "Checklist", which guides surgeons in specific pre-operative, peri-operative and post-operative surgical procedures, isolates specific steps to be checklisted in the world's operating theatres. Personally, I had the honor of meeting Sir Liam when the ceremony was concluded.

Next, several noted speakers were introduced by Dr. Atul Gawande. These representatives of hospitals, healthcare systems and international professions expanded on their endorsement of the utility and application of the **Surgical Safety Checklist.** There were representations from the USA, UK, Canada, India, Jordan, New Zealand, the Philippines, Tanzania, Ireland and Costa Rica. Through several video and TV transmissions and individual delegations of more than 60 medical professional organizations declared their active endorsement on behalf of these safe surgical procedures and millions of patients undergoing these operations. This listing increases daily, said Dr. Gawande

Dr. Margaret Chan, Director General of WHO, closed the proceedings with stirring remarks on the outreach of this and other health initiatives sponsored by WHO. It was a very proud experience for me to attend this ceremony and to see the excitement and impact of patient safety in so many quarters across the world.

Sue Sheridan, Patient for Patient Safety Programme Lead

Sue Sheridan, External Lead of Patients for Patient Safety of the World Alliance for Patient Safety represented the global patient voice at the Safe Surgery Saves Launch on June 25th. In her presentation she referenced the London Declaration and recognized and celebrated the valuable role that patients can play in making Safe Surgery a reality. She challenged the audience to "think big" and called for robust partnerships including patients, providers, professional organizations and governments to implement the use of the Safe Surgery Check List as well educating and empowering the patient population. Sue shared patient stories of harm from unsafe surgery from the UK, United States, Egypt and the Philippines and reminded the audience that those who have suffered are real people and not just statistics.

You can watch the full speech on youtube at: www.youtube.com/watch?v=fOZbzkvrehU

Education Meeting, Geneva

As medical care becomes ever more complex, and patient safety knowledge more sophisticated, it is increasingly recognised that patient safety needs to be introduced into all levels of healthcare worker training as a matter of urgency. Internationally, many medical schools lack a syllabus and teachers confident to deliver patient safety education. The WHO World Alliance for Patient Safety is developing a curricular guide for medical schools, aiming to identify the topics which should be covered, and to support teachers in delivering this. The programme is being led by Professor Bruce Barraclough, supported by the Alliance.
Professor Merrilyn Walton and her team from The University of Sydney, Office of Postgraduate Medical Education and Monash University had been tasked with producing the first draft of the curriculum. The WHO Patient Safety Curriculum Guide for Medical Schools Expert Consensus Group met on 2-3rd June 2008 to review this draft. It was agreed that medical students play an important role in improving patient safety, and it is hoped that the curricular guide will improve the level of knowledge and practice of patient safety worldwide. Two Patients for Patient Safety Champions participated directly and Margaret Murphy also presented to the group on her work with medical students around the world.

Jorge Martinez, Patient for Patient Safety Champion, Argentina

As we know WHO is supporting a great change in Patient Safety since several years ago all over the world. The development of this Curriculum will be an extremely important step forward to really achieve the desire goal.
As a Pediatrician I deeply believe that first years of life experience last for ever and become the leader of our mind and future behavior. Schools of Medicine are the place where experience starts for future Medical Doctors, and as well as with a child, we could transmit a touching and complete knowledge related Patient Safety, that will last for ever. I like to think in a better world, children are the future, “when a child is born, reborn the dream of a better world” (Rabindranath Tagore). I think the same will occur with Medical Students if we accompany them.

I believe that all the members of the team attending the meeting, left Geneva with the great hope that we are going to have in our hands a marvelous tool to make a great difference in Medical Education, **Patient Safety always first**. Dr. Noble and his team, Dr. Walton and her team, the expert leader Dr. Barraclough have made an excellent job and provide us with an amazing well designed instrument. Let’s use it, and we’ll see a great difference. Well prepared Medical Doctors next generation will do the change WHO and the world are expecting.

Mingming Zhang, Patients for Patient Safety Champion, China

Invited by WHO as a Patients for Patient Safety Champion, I enjoyed attending this meeting because patients' voice or perspective were recognized through the whole discussion when developing the curriculum for undergraduate students. There are 11 topics to be covered for patient safety education, one of them is 'Engaging patients and carers in patient safety'. Based on my knowledge and background as a patient champion, I emphasized the importance of patient involvement in each topic, it was recognized. I was invited to a specific topic on 'Engaging patients and carers in patient safety' by providing comments and input. My comments are mainly about students understanding 'patient culture', their stories and experiences in medical errors, the importance of the communication between doctor and patient, communication between doctors and to other healthcare professionals with Disclosure, Transparency, Learning, Recovery, healthcare improvements etc. Thanks to Margaret for her comments, her stories via the teleconference moved participants. Coming back from WHO meeting, I am very busy with my work, one of which is giving tele-distance lecture on patient safety for hundreds of health professionals in over 20 hospitals in China. My lecture title is " Patient safety: a perspective from patient", which is very welcomed by people attending the lecture. This summer time, I will be invited again to give lecture on Patient safety. I will often keep in mind that I am on behalf of patient, so my lecture focus is on 'patient is the centre of healthcare

Reminder: Small research grants for patient safety

REQUEST FOR PROPOSALS

The aim of this new initiative of the WHO World Alliance for Patient Safety is to stimulate research in patient safety worldwide, by providing funding for small research projects. It is envisaged that the initiative will also contribute to building local research capacity as well as help raise awareness about patient safety issues. **Proposals to identify, develop and/or test local interventions for improving patient safety as well as studies on the cost-effectiveness of risk-reducing strategies are invited.**
Funding will be available to support up to 30 projects to begin in 2009. Grants of between US$ 10 000 and US$ 25 000 per project will be awarded on a competitive basis. The grants will target well-defined research projects, which can be completed within 12–18 months. Research in all methodological and clinical disciplines that address patient safety is encouraged. The proposed studies may be conducted in any health-care setting. Research to be conducted in developing countries and countries with economies in transition is particularly encouraged.
The deadline for submissions is 30 September 2008. For further information and to download the application form and other documents please visit: www.who.int/patientsafety/research/grants/.For enquiries, please contact: Ms Nittita Prasopa-Plaizier: Fax: +41 22 791 3712 / Email: pssmallgrants@who.int

Forthcoming Events

East – East: Partners beyond borders Programme

Between 8-10 September in Warsaw the East-East Partners beyond border programme will hold their first meeting.

Organized by the Patients Federation of Poland, in partnership with the Patient Safety Foundation of Poland the project aims to carry out exchange meetings and consolidate efforts of partner organizations in Patient Safety and Patient-Centred healthcare principles implementation in Eastern European region.

The three day event will bring together the International Expert Group, made up of representatives from all the Partner countries, to discuss the existing problems in the sphere of Patient Safety and Patients' Rights Protection in the North-Eastern European region and to get acquainted with the the activity of patients, advocacy and governmental organizations which are related to public health, to find possible ways to resolving them. Key aims of the overall project and the long and short term goals of activity will be developed and a Press Conference in order to raise awareness of patient-centered care and patient safety to the wider population will be held.

Participants are attending from Estonia, Latvia, Lithuania, Poland, Czech Repulic, Slovakia, Hungary, Belarus and Russia.

It is hoped the meeting will result in the publication of an information booklet on the project which can be shared more widely.

To find out more about this project you can contact:

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or

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News from the event will be included in the next edition of PFPS News!

Patient Safety in the Africa Region

Patient Safety issues will be on the top of the agenda for the Ministers of Health during the 58th session of the regional committee to be held in Yaoundé, Cameroon, from the 1st to the 5th August 2008. In fact a technical paper entitled "Patient Safety in the African Health Services: issues and solutions" will be presented to them for decision.

Don't forget if you have any news you want to share or events you want to alert others to, please send them through to Anna at safetyadmin@patientsorganizations.org for forthcoming editions.

The next edition will be out early October. Deadline for contributions is 26 September 2008!