



Patients for Patient Safety News

January 2008



Happy New Year! Welcome to the first Patients for Patient Safety News of 2008! This month is packed with PFPS Champion activities with a particular focus on partnership development at a regional and national level. There is also news of new patient safety initiatives and reminders of opportunities for you to share your experience, knowledge and perspective!

Action across The Americas!

- Alexo Esperato Martinez, Patients for Patient Safety, Pan American Health Organization

Since the celebration of the II Regional Patients for Patient Safety Workshop (Chicago, 2007), the Quality Project at PAHO Washington has continued supporting the articulation of the patient movement in the Americas, as well as individual WHO Patient Champions in the improvement of patient safety in their home countries. The experience gained in this process has helped our team consolidate our work with Patient Champions, summarized as follows:

- ✚ Leadership of the patient agenda and its activities are owned by the patients themselves, while the PAHO Quality team will continue providing technical cooperation and orientation to the patient movement and Patient Champions;
- ✚ Experience has shown it is simpler to incorporate the patients' voice in ongoing interventions than to start projects anew; the PAHO Quality team will give preference to such initiatives;
- ✚ In supporting the patient movement and individual actions, the PAHO team will continue capitalizing on its core strengths, which are institutional brokerage, development of general infrastructure for patients, and technical cooperation.

During December and January, Progress has continued on several fronts. Committed patients in Canada and Peru have made significant advancements towards the establishment of national patient platforms. This month Marcelo Korc, father of a blind girl due to retinopathy in prematurity (ROP), and Alexo Esperato presented in Panama the project for the establishment of a Latin American network of parents of children with ROP. The project has received a warm welcoming from the leading clinical specialists in ROP from our Region (ophthalmologists, neonatologists, and nurses), the majority of which committed to volunteer in the technical committee of the network. Last but not least, Claudia Cattivera and Agustín Ciapponi from Argentina have completed a database with over 300 patient organizations in Latin America and the Caribbean. This database will be an essential input for the Observatory of Quality of Healthcare and Patient Safety, a major undertaking in our office. The research took over 6 months of work, and was part of a joint project between PAHO/WHO, IECS-Argentina, and pacientesonline.org.

Our Patient Champions are gaining visibility both nationally and internationally. Nora Espíritu, from Peru, and Tomás Flores from Mexico delivered presentations at the 3rd International Patient Safety Conference in Madrid (Spain) on December 13-14 of last year. This event, organized by the Spanish Ministry of Health and Consumption, gave Tomás and Nora the opportunity to present their experience as Patient Champions. Tomás and Nora have summarized their experience as follows (edited):

- ✚ **Nora Espíritu:** "Throughout the whole Conference researchers, policymakers and patient champions shared their experiences and demonstrated that patient safety does not know geographical barriers. It was a great joy to witness the declaration and commitment of the Spanish patients for safety in their national health system, requesting and offering commitment, honesty, transparency, participation, as well as focusing their energy to ensure that all people, in all health centers, receive the safest treatment and care. We feel that our network is growing and being strengthened, and that safety as a basic right is becoming a reality".

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✚ **Tomás Flores:** "The first good impression was realizing that students from the Faculty of Medicine (Universidad Complutense de Madrid) were involved in the organization of the conference. Medical students are the future of improved medical attention and avoiding adverse events. During the questions and answers session, a person (presumably a doctor) claimed that "it is only enough to have two careful eyes to avoid kernicterus (a brain lesion affecting my son Chris, whose accurate diagnose requires a screening of bilirubin in the blood stream); careful eyes would be sufficient to decide whether or not to treat the jaundice in a newborn". These words confirm the challenges that patient safety actions must face everywhere, and confirm the lack of information on kernicterus amongst health workers, translating translate into the need for further advocacy and information on this condition. On a positive note, this conference may have been a first major step for the prevention of kernicterus in Mexico: one of the representatives of the Mexican government in the audience, who is in charge of the Ministry of Health's prevention programs promised to take action on Kernicterus, suggesting actions such as the nation-wide provision of prevention programs or courses at hospitals and health government institutions.

The experience of Nora and Tomás bear witness to the engagement of our Patient Champions in the Americas, thereby contributing to the positioning of the patient in the center of safety interventions.

The Spirit of Partnership

At the Patients for Patient Safety Regional Workshops held so far, partnerships have been created between patients and family members of those who have experienced medical error and Medical Professionals and Policy Makers. Some of these 'teams' have returned home and are now working together at the national level to bring about change *together*.



Partnership and Action in Israel

- Sara Yaron, Family Member and Yael Applebaum, Ministry of Health, PFPS Champions, Israel

Since returning from Dublin, we have been busy planning and working together on various projects. Our goal is to increase patient involvement in promoting a safer healthcare environment.

Our major efforts have focused on founding a national organization in line with Patients for Patient Safety. We have recruited additional patient activists and healthcare professionals to form a founding committee. The committee is drafting our mission statement and agenda. We will implement hard-learned lessons gathered from the experiences of others around the world, adapting them to our local culture. We are actively seeking the participation of all stakeholders.

Other activities we are engaged in include the preparation of dedicated standardized forms for patients to report safety issues they encounter. Efforts are being made to include input from patients when investigating medical errors and to encourage structured mediation between involved partners after errors and mishaps happen, before litigation takes over.

To find out more you can contact either Sara or Yael at:

Sara - aron-i@bezeqint.net

Yael - Yael.APPLBAUM@moh.health.gov.il



Patient Safety in Slovenia: Partnering to achieve our common goals

- *Vlasta Gjura Kaloper, Patient, and Vladimira Leskovec, Ministry of Health, PFPS Champions, Slovenia*

1. Common activities:

We both attended the Workshop "Patients for Patient Safety" and International Patient Safety Conference in Dublin in September 2007. These two events were a great opportunity to get the most relevant data about what is going on in patient safety in Europe and to see how dialogue between all stakeholders can be possible. At the same time we got chance to discuss our common goals, how to improve patient safety in the whole of Europe and in Slovenia in all settings of healthcare.

After coming back home from Dublin we had two working meetings at the Ministry of Health to discuss about action plans and issues in the field of patient safety. We both agree that the first stage is to raise awareness among health professionals, patients and their families and among the public in general on a national level.

We decided together to launch and prepare two information leaflets on patient safety. One is meant for health professionals to be more aware how to launch and provide patient safety. The second leaflet is designed for patients and their families and all other users of healthcare services. The main purpose of this leaflet is to raise awareness and empower patients to know better their rights and finally whom to contact in case of confronting any problems.

Furthermore, we are trying to introduce and promote the Patients For Patient Safety programme.

In 2008 we are both involved in a project "Eastern European and Asian Patients Organizations for Patients Rights and Safety" being led by the - All-Ukrainian Council for Patients' Rights and Safety.

2. Ministry of Health, Department for Quality and Safety: Building Partnership in the Field of Patient Safety

On behalf of the Department for Quality and Safety at the Ministry of Health (MoH) we would like to introduce the very important latest news on first Slovene Presidency to the Council of the European Union from 1st January to 30th June 2008. On this occasion we send our kindest greetings to all PFPS champions all around the World, and particularly to those in European Region.

Slovenia's major priority in the field of health during the presidency is reducing the burden of cancer disease, which remains one of the more severe public health problems in all EU Member states. The second priority is reduction of alcohol use and the damage associated with excessive consumption. The third priority is introducing e-Health presenting during the conference which will take place in Slovenia during the Presidency and will be organized by the Ministry of Health of the Republic of Slovenia.

There will be also some other activities going on during the Presidency to promote health in general, encouraging a more healthy lifestyle to all citizens, particularly to encourage them to use healthy nutrition and physical activity, prevent them from communicable diseases and to find applicable innovations in healthcare and better accessibility of healthcare services respecting six dimensions of quality: equity, effectiveness, safety, timeliness, efficiency and patient-centred healthcare.

Of late years The Department for Quality in Healthcare at the Ministry of Health has been very active in introducing quality and patient safety at all levels of health care in Slovenia. The first Slovene national conference on Patient Safety took place in 2006 in Ljubljana organized by the Ministry of Health, the Institute of Public Health of the Republic of Slovenia, the British Embassy in Ljubljana, WHO, the Medical Chamber of Slovenia, the Nurses and Midwives Association of Slovenia and the Council of Europe.



In 2006 the Ministry of Health for the first time conducted a National Patient Experiences Survey in all Slovene acute and psychiatric hospitals. Second reports on survey findings from 2007 will be prepared and issued in 2008. At the same time The Ministry of health had required these hospitals to appoint Quality Coordinators to facilitate the introduction of patient safety indicators and quality improvement tools.

Ministry of Health has published also several papers and publications to improve quality in healthcare and patient safety. One of the most important papers is the National Policy for the Development of Quality in Healthcare from 2006.

In October 2008 we are planning to conduct information workshop for health care professionals to introduce new reporting system on sentinel events in Slovenian hospitals. For that occasion we are preparing leaflet which is dedicated to sentinel events and it is meant for managers and health professionals.

We are preparing a translation of the Declaration on Patient-Centred Healthcare into Slovene language. Soon we will invite all the healthcare professionals in Slovenia to present the exchange of best practices in the field of patient safety and quality and will be accessible on www.mz.gov.si.

Finally the Department for Quality in Healthcare at the Ministry of Health will be in 2008 one of key partners of the project "Eastern European and Asian Patients Organizations for Patients' Rights and Safety" for the regional group "Countries of Balkan Peninsula, Moldova and Ukraine".

PROGRAMME OF THE CHRONIC PATIENTS MULTIPLIER ORGANIZATION **- Vlasta Gjura Kaloper, Patients for Patient Safety Champion, Slovenia**

The purpose of bringing together all chronic patients organizations and associations is solving our common problems. The multiplier organization will represent the interests of all patients in agreement with health authorities and health care institutions. There have been similar attempts of unification in the past, however, I believe that up until now the time did not favour that option. Today, the patients are aware we have to be made equal partners in the formation of health policies and health care.

I present the draft programme of the Slovenian Chronic Patients Multiplier Organization.

- 1) Patient Rights Act: participating in the formation of the Act, particularly in the part dealing with the patient rights ombudsman.
- 2) Health Care and Health Insurance Act: participating in the formation of the article on comparable medicines.
- 3) Ensuring patient safety in health and social institutions; participating in the reports procedure of undesirable events.
- 4) Setting up our own webpage – ensuring that information on our activities reaches wider public.
- 5) Cooperating with Slovenian health authorities, Health Insurance Institute and health care providers to achieve greater quality of health care, which is in our common interest.
- 6) Raising funds to finance our projects and cover the necessary expenses.
- 7) We will actively cooperate with similar patient organizations in the EU and the world.

Vlasta and Vladimira's **Plan of Action in** **Partnership** (Key Next Steps)

1. Regular cooperation and meetings with NGO's and other individuals in Slovenia, promotion of PFPS. Translation into Slovenian IAPO's Declaration on Patient-Centred Healthcare.
2. Prepare, print and distribute materials- information leaflets and posters to raise awareness of health care professionals and patients and their families about patient safety and sentinel events.
3. One of the key partners in project "Eastern European and Asian Patients organizations for Patients' Rights and Safety".
4. Preparation of workshop on patient safety and sentinel events for health care professionals.
5. Planning Patient Safety Workshop in Slovenia for healthcare professionals and patients, patients and their families.
6. Conference on Quality in Healthcare will take place in Kranjska gora, Slovenia, MoH of Slovenia and ESQH.



CHAMPION ACTIVITIES



Patient Safety: My Journey

- Rebecca O'Malley, Patients for Patient Safety Champion, Ireland

In the early summer of 2007 I shared with an astonished nation the story of how my breast cancer had been misdiagnosed, thereby causing a 14 month delay in the start of my treatment. I did this because my questions - "How did this happen?" and "Who else might be affected?" had remained unanswered. After a highly publicised campaign, an independent investigation was eventually launched, the results of which will soon be published.

Sadly, my case was the first in 2007 of at least 10 further cases of women in Ireland whose breast cancer was misdiagnosed at different hospitals around the country. As a result, these women all commenced treatment much later than they should have done, thereby compromising their chances of survival.

During many media interviews, I argued for a greater openness and honesty between the medical establishment and patients; a more patient-centred approach to healthcare and patient safety; and, crucially, for the mandatory reporting of medical errors both to the patient and to an independent body.

My journey led me to two particularly interesting events. In September, I attended the WHO World Alliance on Patient Safety Euro Conference in Dublin and committed myself to the London Declaration.

In December I attended a Stakeholder's Consultation Meeting, also in Dublin, entitled: "Open Communication in the Healthcare Setting – The Way Forward for the Republic of Ireland?". It was hosted by the Health Service Executive's Clinical Indemnity Scheme, the body that covers all claims alleging medical malpractice or clinical negligence against an agency and/or its staff arising from the delivery of professional medical services by those employed by the agency.

I was privileged to be invited to give the Patient Perspective at the meeting and my presentation focussed on a couple of key points within the open disclosure setting: The language of medics, the jargon they use and how that continues to alienate the patients they seek to help; the myth of perfection that surrounds doctors, how this has prevented the development of effective methods of error prevention and the role that education has to play in exploding the myth; mandatory reporting of medical errors to the patient and how making reporting systems mandatory in other non-medical settings hasn't proved to be a deterrent to reporting; and a 'recipe card' for what patients and their families expect from an open disclosure meeting – a great 'recipe' given to me by Patients for Patient Safety Champion, Ryan Sidorchuk, in Canada.

During the day we also heard from Hilary Coates, International Patient Safety Liaison with Ireland's Health Information and Quality Authority, who introduced the project that she is leading in collaboration with the World Health Organisation's World Alliance for Patient Safety; and from Mr Ciaran O'Rourke, Solicitor, and Dr Colm Quigley, President of the Irish Medical Council, who gave the Legal Perspective and Clinician's perspective respectively. We also heard from Dr Mark O'Brien of the Cognitive Institute in Australia and New Zealand, one of the world's largest providers of communication skills training to healthcare professionals.

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Included amongst those in attendance at the meeting were members of the Commission on Patient Safety and Quality Assurance who have, amongst other issues, been asked to examine all aspects of the reporting of medical errors. The Commission will report to the Minister of Health in the summer of 2008 with their recommendations.

Throughout all the meetings and presentations that I have attended since last summer, I have detected a growing acceptance amongst all those involved in the debate that the reporting of medical errors now needs to be placed on a more mandatory basis. It will be interesting to see if this is translated into specific and effective actions.

I now await the publication of the findings of the investigation into my misdiagnosis and I know that when that happens I will be busy once again as I take every opportunity to highlight the crucial need for learning to take place following a mistake within the healthcare setting.

If anyone is interested in reading the presentation I made in December, then I would be happy to share it with them. I can be contacted directly at theomalleys@eircom.net

GAMIAN Europe proposals for patient safety in mental health field

- **Emma Gruber, MD**, President of 'Happy family' – Society for improvement of mental health and quality of mentally ill patients and their families, and PFPS Champion, Croatia

- **Monika Nemanytė**, GE Board member, Club 13&Co., and PFPS Champion, Lithuania

We, patient safety champions recognized not having any specific goals and guidelines stated on mental health issues so we organized a workshop for GAMIAN Europe members on Patient Safety in Croatia at the end of last year, during the X Gamian Europe conference.

Gamian Europe members discussed, observed and articulated the following problems:

- Lower quality of medical services because of mental patients stigma & discrimination
- Lack of compliance in therapeutic process which causes unsafe situations (refusal of medication, wrong medication or dose)
- Medical mistakes in treatment related to the fact that mental patients physical illness is often disregarded and neglected, patient is not treated holistically and although some medications interact with metabolic factors, blood tests for cholesterol levels or measuring the patient's waist are not common practice.
- Low awareness about side effects of psychiatric medication
- Patients with severe/chronic mental illness can be easily misused or manipulated.
- Low availability of medical services or pharmacist advices during vacation or holiday times and weekends
- Professionals not always respect the law of confidentiality
- Patients with severe/chronic mental illness have right on second opinion in their treatment
- Patients with severe/chronic mental illness have right in asking funding for their empowerment and right on proper information about their illness

GAMIAN Europe proposals for patient safety activities in the mental health field:

- Raising awareness about patient safety in mental health field
- Partnership of all key players (experts, professionals, families, patients and industry)
- Education of patient advocates and patients for patient safety champions
- Dissemination of good practice and solutions to prevent medical errors and improve patients safety
- Treating patients holistically and since some psychiatric medications interact with metabolic factors, blood tests for cholesterol levels and measuring the patient's waist as well as the other metabolic tests should be common practice.
- The power of detaining patients in a place of safety (secure hospital ward) against their wishes should be used properly and according to the law.
- Forming an inspection body that inspects services and quality of care and to check safety standards for example with patients who may be suicidal, human rights, drug prescribing, ECT, seclusion etc.
- Learning from experience of mentally ill patients (patient is an expert of his own experience, he is in a center of health care system and should be seen as a compass, conscience, teacher, catalyst and witness)
- Changing of European mental health policy to cover care of both physical and mental health.



News from Patients for Patient Safety Denmark!

- Birgit Hartoft, Patients for Patient Safety Champion, Denmark

- Vinnie Andersen, Danish Society for Patient Safety

Saturday 2 February 2008 the Danish Patient Champions met for the year's first network meeting to plan the new activities for 2008.

The two main activities for 2008 will be:

- The dissemination of the film "Listen to Us!"
- Preparations for a national Speak Up campaign about patient safety aimed at the ordinary consumer.

In the autumn of 2007 we planned and shot a film, in which 4 of us Patient Champions told our stories of mistakes made in the treatment of ourselves or our relatives. Common to all four stories is that if the health professionals had taken the time to listen and act on the insights and concerns of the patient and/or relations, the patient would not have been harmed. The film is now to be launched in such a way that the message reaches as many as possible. We aim to reach out both nationally and locally to Mr and Mrs Denmark, and to both the decision makers and the professionals at the coal face of the health system. Where the film has been shown, it has led to great thoughtfulness and a renewed will to include patients in the work towards improving patient safety. The film runs for 17 minutes, it has been subtitled in English, and in the next newsletter, at the latest, we will tell you where you can see it!

In Denmark traffic safety and bathing safety are familiar subjects. But next to no one – outside of the health system – knows what patient safety is about. That shall be changed! Therefore we wish to start a wide-ranging campaign about patient safety aimed at raising the awareness of Mr and Mrs Denmark. The campaign will naturally take its offset in the fact that patient safety is the responsibility of the health system. However, we wish to encourage patients and relations to (dare) use their own resources if/when they or their relatives become patients. For their own safety's sake.

Patients and relatives will be encouraged to become more aware of safety issues, and encouraged to be active in taking care of their own and other people's patient safety through a number of simple precautions; such as asking until one understands what is going to happen; by telling the health professionals about one's habits; by knowing one's medication; by checking one's name at each examination, treatment, and when taking medication; by asking the surgeon to mark the place you have agreed on as the site of the operation to be done, etc. Towards the end of May we intend to hold a two day workshop, where ideas and plans can be worked out so that the campaign can start off at The National Patient Safety Conference in 2009.

The Danish Patient Champions met for the first time in April 2007. At the initial workshop we agreed on a number of recommendations concerning how patients and relatives want to be treated by the health professionals "when harm has been done". These recommendations were presented at The National Patient Safety Conference the same year, and caused The Danish Society for Patient Safety to establish a working group to develop guidelines on how the health system should meet patients who have been harmed. The working group consists of representatives of the Patient Champions, The Medical Association, The Nurses' Organization, the owners of the hospitals, etc. We expect that a set of recommendations will be presented at The National Patient Safety Conference on 21 April 2008.



Patients for Patient Safety Denmark Network



Other Patient Safety News

Patient Safety Awareness Week March 2 to March 8, 2008

PATIENT SAFETY AWARENESS WEEK
Sponsored by National Patient Safety Foundation® 

Patient Safety - A Road Taken Together

Hospitals, healthcare organizations and patient groups across the globe will join the National Patient Safety Foundation in celebration of Patient Safety Awareness Week, March 2-8. The theme of the week, *Patient Safety: A Road Taken Together*, emphasizes a collective effort for safer health care through partnership among providers, patients, families and communities. Founded in 2002 by NPSF, this week is intended to raise public awareness about the work being done to improve patient safety and the importance of effective partnering to these improvement efforts. Community engagement provides a key focus for the week's efforts.

During Patient Safety Awareness Week 2008, NPSF will join forces with the World Alliance for Patient Safety, Patients for Patient Safety programme to focus on the issue of health literacy and effective communication as key factors for improving patient safety. NPSF's Partnership for Clear Health Communication will provide its *Ask Me 3* program for dissemination through Patients for Patient Safety. This program, a health literacy initiative designed to assist with communication between patients and providers through a focus on 3 basic questions - *What is My Main Problem? What Do I Need to Do About It and Why is It Important for Me to Do This and What are the Risks?* – has been translated into the six official languages of the WHO and will be disseminated worldwide through the Patients for Patient Safety Champions network as they work in partnership with these healthcare system.

"Patient Safety Awareness Week is a call to action that promotes patient safety and the importance of partnership in improving safe outcomes," said Diane C. Pinakiewicz, NPSF President. "Effective communication between providers and patients is key to the type of partnership necessary for this work and we are pleased to be joined by the World Alliance for Patient Safety, Patients for Patient Safety programme as we focus on communication and community engagement this year."

NPSF's more than 400 Stand Up for Patient Safety™ healthcare facilities will spearhead the celebration in the United States as they reach out to their communities to engage them in the work they are doing in patient safety. NPSF provides its members with programs for the week that include tools for community education and engagement.

If you are interested in receiving more information regarding National Patient Safety Awareness Week tools and resources visit <http://www.npsf.org/hp/psaw/>. For more information on how patients, families, healthcare providers and your community will celebrate the week, please contact Bernadette Lupo at (413) 663-2018 or blupo@npsf.org.



Multiple Conditions Working Group

- Dr Christine Walker, Chronic Illness Alliance



The Chronic Illness Alliance is an Australian Not for Profit group that is concerned with building a better focus in health policy and health services on the needs of Australians with chronic illnesses.

In August 2007, the Committee of Management of the Chronic Illness Alliance in Australia established the Multiple Conditions Working Group. This Working Group is comprised of people with multiple conditions, their carers and their representatives. The aims and scope of the work being undertaken is determined by people with multiple conditions themselves.

The basis for this new working group is that the Alliance recognises that many people have more than one chronic illness; that when a person has one chronic illness they may be at greater risk of developing other chronic illnesses. Additionally people with chronic illnesses are more likely to suffer adverse events and medical errors because they have greater contact with the health system than others requiring acute care. The possibility of error and adverse events increases if a person has more than one condition.

The Alliance ran an exploratory workshop in August and participants reported that as well as their primary conditions some people had Type 2 Diabetes, depression, asthma and musculoskeletal conditions. Many of those participating had three or four conditions. In some instances, participants had developed a condition as a direct result of their primary condition, while in other instances it was a side-effect of the long-term treatment they were on. For another group, participants had developed a condition from an adverse event.

In some cases multiple chronic conditions are a consequence of improved treatments and care. People with cystic fibrosis and thalassaemia, for example, are now living much longer than was anticipated even a few years ago. While they value this improved life expectancy, it is sometimes accompanied by the development of other conditions such as cardiomyopathy, Type 2 Diabetes and renal failure in the case of thalassaemia or CF-related diabetes in the case of cystic fibrosis.

Depression was a problem for many of the participants. While there may be a well-documented relationship between having depression and Type 2 Diabetes there was also a strong relationship between living with a rare chronic illness such as thalassaemia and living with uncertainty about one's life expectancy or living on low incomes due to incapacity to work. Depression was also likely to be significant when a person's quality of life was reduced due to an adverse event.

Participants believed that many people with multiple conditions missed out on services because they did not fit some of the guidelines; they were treated for a primary condition and the other conditions were not considered as important. Some people with multiple conditions could not afford the time or expense of travelling between the various services. Most importantly where rarer conditions were concerned, health professionals did not always have the experience of treating the complex interrelationship of conditions.

The workshop developed its own draft definitions of 'multiple conditions'. These definitions are not clinical ones but ones that provide directions for the Working Group to pursue a program that will lead to improved understanding of what it is like to live with multiple conditions.

Draft set of definitions

A cluster of health conditions that create a complex relationship between individuals and the health system;

A cluster of health conditions that require negotiating systemic barriers to achieve the best outcomes for individuals with these conditions.

Draft aims

To identify those organisational and political conditions that together create complexity of service management for people with multiple conditions;
To identify those systemic barriers to optimal care for people with multiple conditions.

The Multiple Conditions Working Group is currently seeking sponsorship and funding to develop a discussion paper which will provide direction on removing some of those barriers and ultimately assist people with multiple conditions to achieve a better quality of life.

If there are other organisations working on these matters we would be pleased to hear from them.

You can email Christine at: cwalker@chronicillness.org.au



World Health Students Symposium

- Margaret Murphy, PFPS Steering Group
- Helen Hughes, World Alliance for Patient Safety

At the end of last year we were asked to take part in the World Health Students Symposium in Portugal. Together with Felix Greaves, Clinical Advisor at the World Alliance for Patient Safety, we supported a workshop on Learning from Error. The event gathered together more than 500 multi-professional students; medical, pharmacy, nursing and health technology. They were very interested in learning more from the patient perspective and there was a really buzz about patient engagement.

This was a great opportunity to work with the healthcare leaders of the future and to inform them about patient safety and the importance of patient engagement. Having an opportunity to work with the new generation will allow grounding in the creation of a new patient safety culture, which will take a generation to change.

Sharing personal experience of medical error and the learning that can be gained had a powerful impact on the students, affecting hearts and minds. The value and importance of the patient experience in learning was evident. We are not just about sad stories but our experience really engages the audience and helps to hit home the key learning opportunities.

There is a clear need and hunger for training and resources to support these students in their development. We have developed a very good Learning from Error training package and it will be essential that we consider, over the coming months as it is finalised, how Patients for Patient Safety can support its dissemination and use. This event made it very clear the hunger for formal Patient Safety modules in education activities and the importance of a multi-professionals working and training on Patient Safety together.

To find out more you can email Margaret on m33g33t@yahoo.co.uk



Patient Safety: Opportunities for Engagement and Partnership

3rd Global Patients' Congress – International Alliance for Patients' Organizations (IAPO)

Patients for Patient Safety has been asked to lead a workshop at the forthcoming Global Patients Congress being run by IAPO in Budapest, Hungary 20-22 February. As part of their workshop programme IAPO are running a strand throughout the event which is focused on Patient Safety, it will include the launch of their new Patient Safety toolkit and a session looking at specific issues for Eastern European countries around patient safety.

Key note speakers for the event include:

- **Sir Liam Donaldson**, Chair, WHO World Alliance for Patient Safety
- **Mr Gábor Demszky**, Mayor of Budapest
- **Andrzej Ryś**, European Commission, DG SANCO – Director, Public Health & Risk Assessment
- **Dr Linda Milan**, WHO Western Pacific Regional Office Director, Building Healthy Communities and Populations
- **Ms Katalin Rapi**, Secretary of State for Health Policy, Ministry of Health, Hungary

The Congress is open to members of IAPO and selected invited guests. If you are a patients' organization and interested in learning more about the 3rd Global Congress or becoming a member of IAPO please contact:

Esther Thompson at
membership@patientsorganizations.org



Opportunities to share your wisdom!

International Solutions for Patient Safety

The World Alliance for Patient Safety, Patients for Patient Safety invites you to review and comment on the next set of proposed *Patient Safety Solutions* that have been developed by the WHO Collaborating Centre for Patient Safety Solutions (The Joint Commission). The Collaborating Centre's foremost priority is the identification and refinement of Solutions that support patient safety improvement efforts around the world. In May 2007, the Collaborating Centre released the first set of nine *Patient Safety Solutions* (www.jcipatientsafety.org/ninesolutions).

The international Internet-based field survey is one of the most critical stages in the Solutions development process. The Collaborating Centre specifically seeks opinions from the international community regarding the content, feasibility, and applicability of these Solutions. They are also interested in input as to potential barriers to using the Solutions and ways in which the Solutions may need to be adapted to accommodate cultural realities in different regions of the world.

Please access this survey by directing your Internet web browser to www.jcipatientsafety.org/survey. This on-line survey can be accessed at any time and, if necessary, completed in separate sessions. You are encouraged to complete the entire survey but they will accept survey responses that are submitted for individual Solutions. **The deadline for submitting responses is February 29, 2008.**

The five new Solutions were developed with the guidance and assistance of an International Steering Committee of patient safety experts. The Solution topics were prioritized by the Steering Committee and then formulated based on the available evidence in the patient safety literature. The draft Solutions were further refined based on comments received from JCI Regional Advisory Groups in Europe, and the Asia Pacific; the Middle East Regional Advisory Group will meet later to review the draft Solutions and provide comments. The JCI Regional Advisory Groups are composed of recognized health care leaders and patient safety experts.

The Alliance also invites you to comment on your experience to date in using some or all of the first set of nine Solutions. If you have questions about the survey, please contact **Gerry Castro**, Project Director, at the Joint Commission International Center for Patient Safety (gcastro@jointcommission.org).



PATIENT PARTICIPATION AND HAND HYGIENE IMPROVEMENT

In the last edition of PFPS News we announced the launch of the second round of the Hand Hygiene Survey which forms part of the work of the Global Patient Safety Challenge, Clean Care is Safer Care work on Hospital Acquired Infection and Hand Hygiene.

For those of you who have not yet had the opportunity to share your views in this survey we would like to encourage you to visit the online survey by going through the Global Challenge website home page – www.who.int/gpsc or directly at:

http://www.who.int/gpsc/patient_survey/en/index.html

The survey is available in the six WHO languages – English, Spanish, French, Russian, Chinese and Arabic.

Please feel free to circulate this information to those in your networks that have not had the opportunity to complete it previously. This is a great opportunity for patients globally to share their knowledge and wisdom. We are very grateful for everyone's time in completing this.

The deadline is **Friday 29 February 2008**

If you have any questions about the work of the 1st Global Challenge, Clean Care is Safer Care then please visit the website or contact Julie Storr, Project Manager, at storj@who.int



Dates for the Diary

2nd International Patient Safety Congress, 25-29 March 2008, Antalya Turkey

It is our objective to exchange knowledge and experience with our colleagues from all over the world; we have the intention of bringing together also those organizations that do not have access to the relevant resources. Within this context, the Turkish Patient Safety Association would feel honored to provide various grants for those participants who wish to join us at the Congress.

For information on topics, speakers etc related to the Congress visit our website:
www.patientsafetycongress.net.

If you are interested in applying for a grant please email Ece Agusman from the Turkish Patient Safety Association at: ece@networkproduction.net Please note for those receiving a full grant this will include: All food and drink, full attendance to the congress, all-inclusive accommodation at a 5-star hotel for 4 days but not travel/airfares.

INTERNATIONAL FORUM ON Quality and Safety in Health Care

22-25 April 2008
Le Palais des Congrès de Paris, France

For more information visit: <http://group.bmj.com/group/events/forum>

22 – 23 May 2008 – Patient Safety Congress, UK

Please visit: <http://www.patientsafetycongress.co.uk>

25th International Conference

The International Society for Quality in Health Care
Bella Centre, Denmark, 19 to 22 October, 2008



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 safetyadmin@patientsorganizations.org for forthcoming editions.

The next edition will be out at the end of March so get writing!