# Patients for Patient Safety News

**May 2007**

Welcome to another edition of Patients for Patient Safety News! There are lots of events and workshops taking place so this edition focuses on, not only the regional workshops but also on the great activities that Champions are running in their own countries!

# REGIONAL ACTIVITIES

## SEARO

### WHO Regional Office for South East Asia: *Patients for Patient Safety* Workshop!

Patients for Patient Safety is very excited to be working with the WHO Regional Office for South East Asia to host a workshop event for patients, family members, NGO representatives, health professionals and policy makers from across the region. The workshop is taking place in Jakarta, Indonesia on 17-19 July.

The packed programme includes an opportunity for participants to share their experiences, the lessons they have learnt, their knowledge and their hopes for the future of patient involvement and patient safety within their own countries and across the South East Asia region.

The main objective of the workshop is to build a regional network of champions and partnerships for patient safety that, through advocacy and open dialogue, can bring about effective systemic and quality changes to local health care systems.

Although the deadline for applications has passed if you are interested to find out more about this event then please contact Rachel Heath, Patients for Patient Safety Project Manager at safety@patientsorganizations.org

In the July edition of Patients for Patient Safety News we will update you on the outcomes from this event!

## EURO

### Call for Applications to Attend the European Regional *Patients for Patient Safety* Workshop!

Patients for Patient Safety in collaboration with the WHO European Regional Office will be holding a regional *Patients for Patient Safety* workshop between 3 – 6 September in Dublin, Ireland. We are now seeking applications to attend this workshop from interested patients and consumers from across the European region.

If you are a patient or consumer interested in attending this event please visit the Patients for Patient Safety website to download further information and application documents at: www.who.int/patientsafety/patients_for_patient or email Rachel Heath, Patients for Patient Safety Project Manager at safety@patientsorganizations.org

**Please note the deadline for completed applications is 15th June.**

# PAHO

## Exciting activities in Pan American Region!

- Alexo Esperato Martinez, Patients for Patient Support in the PAHO Region

**II Regional Workshop Patients for Patient Safety – Patient Safety Solutions (Chicago, June 11-13).** This working meeting, joint initiative of PAHO/WHO, Joint Commission/Joint Commission International, and Parents of Infants and Children with Kernicterus (PICK), will bring together patient leaders and mother-child health program managers and experts, with the main objective of designing common strategies for the inclusion of the patient perspective in patient safety interventions. Most of the patient leaders invited in this workshop also participated in the I Regional Workshop of Patients for Patient Safety (San Francisco, May 2006). The next edition of this bulletin will contain updated information on the results of this workshop and the status of the patient agenda in the Americas.

**Regional Review of Patient Organizations.** In close collaboration with Pacientes Online (www.pacientesonline.org) and the Institute of Clinical and Health Care Effectiveness (IECS, http://www.iecs.org.ar/iecs-visor.php?cod_producto=26), PAHO/WHO has launched a survey of patient organizations in the Americas. The main objective of this project focuses on the elaboration of a situational diagnostic of the region, identifying the main patient organizations in each member country of PAHO/WHO, thus enabling the construction of a regional directory of patient organizations. The pilot stage generated the retrieval of important information in several countries (Argentina, Chile, Perú, Costa Rica and Honduras), and the validation of the *online* questionnaire used for data collection. The second stage, which is about to start, extends the survey to the rest of the countries in the Americas.

# EMRO

## Eastern Mediterranean Patients for Patient Safety Workshop

- Rachel Heath, Patients for Patient Safety Project manager

This was the second of the planned workshops that Patients for Patient Safety is undertaking across all 6 of the WHO geographic regions. Held in Cairo 26-28 March 2007, this event brought together 30 participants from 8 countries within the Eastern Mediterranean region. The event created a network of consumer champions in the Eastern Mediterranean who are actively engaged in contributing their experience, wisdom and knowledge to improving patient safety. The meeting culminated in several discussions around the topic of patient safety with particular emphasis on the engagement of patients in shaping the healthcare system.

Over the course of 3 days the country 'teams' made up of patients, health professionals and policy makers, shared experiences, told their personal stories, offered learning and best practice and developed action plans and strategies in line with the vision laid out in the London Declaration. The commitment participants made offers a real opportunity to bring patient voices into the patient safety work in the region and to bring patient safety to the forefront of the health agenda. This meeting was characterized by a flavour of passion, compassion and courage.

For more information on the work of Patients for Patient Safety and the WHO Eastern Mediterranean Office please contact Rachel Heath, Patients for Patient Safety Project Manager at safety@patientsorganizations.org.

# IN-COUNTRY/CHAMPION ACTIVITIES

## The Danish Workshop: Patients for Patient Safety, 2007

- Birgit Hartoft, patient participant at Danish Workshop

On the weekend of April 13 to 15, the Danish Society for Patient Safety held their first workshop for "patient champions".
We were fifteen participants, from all walks of life, with as many different focus areas. There were people representing the larger groups of patients with chronic diseases, such as multiple sclerosis, there were stroke victims, victims of botched plastic surgery, and other treatments, and there were relatives of patients – children, parents, spouses - who had lost their loved ones due to accident or wrong treatment. Together we represented the patient side of most of the health system from private clinics and nursing homes, to cancer departments and psychiatric hospitals.
Over the weekend we became acquainted with each others' stories, and found common ground for our wish to prevent serious errors from happening to other patients. We each carry a tragedy which has struck us hard and changed the direction of our lives. We have each experienced happenings which have damaged our trust in the Danish health system. And we have all reached the point where, rather than complain to each other and to friends, we want to help change the system and prevent errors.

We all know that to err is human, and therefore errors will occur. But we also know from our own experience that errors could have been prevented with the right approach and the right procedures. We do not wish to point fingers, or hang people out to dry on the front pages of the tabloids.
What we do want is to engage in a dialogue with doctors and nurses representing the health system, to contribute with our different and unique experiences as patients or relatives of patients. Doctors and nurses wander in and out of a patient's life, only the patient stays the course. Therefore the patient (or relative) has a unique insight, and it is a waste not to take advantage of it.
Doctors and nurses don't set out to make mistakes – no one does. But mistakes happen, and – sometimes – harm is done. As patients and relatives of patients we want to be taken seriously as partners in the process of treating our diseases and helping us to die with dignity. If harm is done or narrowly averted, we don't want to be treated like minors without minds of our own, nor do we want to have the truth hidden from us.
As patient ambassadors with our unique experiences we put ourselves at the disposal of the health system to help change attitudes from the defensive "we're doing the best we can, and it cannot be done any better", to the open-minded "we acknowledge that we make mistakes, but with every mistake we learn how to do better next time".
There are many ways we can help – give interviews, write articles, give talks at conferences, participate in root cause analyses, work out recommendations on how to communicate with patients and relatives, participate in changing processes and procedures, act as "assistant" to patients, and many more. We are open to suggestions, and we hope our experiences will be of help to future patients.

The very first result of our work was a task given to us for the workshop: To work out a set of guidelines on how we want to be met, when the error has been made, and harm has been done.

**When harm has been done**
This is how we want to be met
.

**Take good care of us when we are patients**

**Show patients and relatives respect**

- Talk to us
- Meet us where we are
- Look us in the eye
- Listen to us, and hear what we are saying
- Respect our experiences – they are genuine
- Include us

**See us as genuine partners**

- Use our knowledge and experience
- Cooperate with us

**1. Carry out damage control immediately**

- Take responsibility, also when **we** are experiencing that something has gone wrong
- Control the extent of the damage
- Control the long term effects

**2. Tell the truth and take responsibility**

- Acknowledge that the harm has been done
- Explain what has happened
- Offer us an apology
- Offer counseling
- Give us the opportunity to talk to the manager and those who have been directly involved, alone and without interruption
- Follow up when you know more

**3. Include us in your root cause analysis**

We see other things than you do, and we participate throughout, therefore:

- Listen to our experience of the incident
- Allow us to comment on the conclusions and recommendations of the analysis
- Use us as team members

**4. Prevent the harm from happening to another patient**

- Report the incident
- Analyse the incident
- Recommend us to report the incident
- Explain to us what you will do, so it does not happen again

## Things are moving in England

- Peter Mansell, Director of Patient Experience, National Patient Safety Agency, UK and Patients for Patient Safety Steering Group Member

**A report aimed at increasing patient participation in patient safety work was published by the British Government recently[1]**

Safety First recommended that the active involvement of patients and their families should be promoted by establishing a national network of patient champions who will work in partnership with NHS organisations and other key players to improve patient safety; the network should also have strong links with WHO World Alliance for Patient Safety's 'Patients for Patient Safety' initiative.

### Purpose of patient safety champions

The purpose of establishing a network of patient safety champions in England is consistent with the purpose of establishing them within the World Alliance and most concisely expressed in the Statement of Case[1]

> Patients for Patient Safety, one of six action areas of the World Alliance, is designed to ensure that the perspective of patients and families, consumers and citizens – whichever term resonates best -- in both developed and developing countries is a central reference point in shaping the important work of the Alliance. Patients and their lay caregivers see things that busy healthcare workers often do not. It follows that safety will be improved if patients are included as full partners in reform initiatives, and learning can be used to inform systemic quality and safety improvements.
> (Patients for Patient Safety Statement of Case)

Therefore the network in England will help our NHS colleagues identify and address patient safety issues by including patient perspectives within patient safety work. This will contribute to the building of trust between clinicians and patients.

**Focus on Improvement**

The model of partnership and engagement is based on improvement, not audit. So activities will be focussed on improvement – making services safer rather than ensuring services are "safe"[1]. Patient champions and network members will be supported in participating as equals rather than victims or subordinate to staff in activities.

> "safety will be improved if patients are included as full partners in reform initiatives, and learning can be used to inform systemic quality and safety improvements".
> (Patients for Patient Safety Statement of Case[1])

### Activities

An important consideration in determining where patient safety champions activities will add most value is to consider the role of established patient involvement mechanisms currently under development in England.

Current national policy envisages the establishment of Local Involvement Networks (LiNKS) to replace Patient and Public Involvement Forums (PPIFS). LiNKS will carry out influencing, planning and monitoring functions with NHS organisations about health and social care in the areas of policy-making, strategic planning, commissioning, and the design and delivery of care services. As such they have a very wide focus and cover developmental, auditing and quality assurance functions.

In contrast the World Alliance for Patient Safety Patients for Patient Safety champions have undertaken a variety of activities all focussed on improvement: at the international level we have participated in the other World Alliance workstreams; at the national level we have initiated discussions with policy makers and lead clinicians on issues of importance in patient safety applicable to our country such as lack of disclosure, failure to mitigate the effects or errors and thematic work; we have undertaken local partnership work with healthcare deliverers on patient safety issues.

The activities Patients for Patient Safety Champions have undertaken are defined in the London Declaration[1]

**We**, Patients for Patient Safety, will be the voice for all people, but especially those who are now unheard. Together as partners, we will collaborate in:

- Devising and promoting programs for patient safety and patient empowerment.
- Developing and driving a constructive dialogue with all partners concerned with patient safety.
- Establishing systems for reporting and dealing with healthcare harm on a worldwide basis.
- Defining best practices in dealing with healthcare harm of all kinds and promoting those practices throughout the world.

In honor of those who have died, those left disabled, our loved ones today and the world's children yet to be born, we will strive for excellence, so that all involved in healthcare are as safe as possible as soon as possible. This is our pledge of partnership.

*March 29, 2006*

Accordingly we envisage patient safety champions in England working in partnership with trusts, other patients and activists within LiNKS to focus and promote improvements in patient safety and greater openness. This will cover all areas and range from: promoting more open disclosure; reporting and learning; developing patient safety solutions around particular thematic areas; addressing the culture of denial; promoting patient participation in patient safety research and campaigning for change.

In addition its hoped that the network will help NHS organisations to identify and recruit patients and those close to them to work in partnership with NHS staff on general and thematic projects and topics in nature aimed at cracking key safety problems; share information between Trusts and network members aimed at promoting action and supporting learning across the NHS; and stimulate a more open, transparent learning culture within the NHS by acting as critical friends to the NHS.

So watch this space!

To contact Peter and find out more, email him at: peter.mansell@npsa.nhs.uk

## Patients for Patient Safety Canada: Mental Health Initiatives

- Francine Chisholm, Patients for Patient Sfaety Champion, canada

I was privileged to participate in the WHO Patients for Patient Safety Canada Workshop in Vancouver, B.C., Canada, in September, 2006 as a consumer educator, researcher and advocate in mental health. It struck me that patient safety and psychiatry/mental health were absent from the table at the international, national and regional levels.

Since this national workshop, I have been engaged in a regional focus group in Calgary, Alberta, Canada addressing the patient safety needs in psychiatry/mental health. I wish to share my experience with this initiative with the international community of Patients for Patient Safety.

In October, 2006 I began an online correspondence with Dr. Michael Trew, Program Medical Director for Primary Care Psychiatry, Darlene Harris, Director, Safety, Risk Management and Business Practices and Iris Penwarden, Risk Management Coordinator, Mental Health & Addictions Services, Calgary Health Region (CHR) in Alberta. We shared thoughts on the patient safety issues in psychiatry and mental health, some emerging patient safety literature in the field, and possibilities for involvement of consumers in potential patient safety programming with the CHR.

The fruition of this discussion was a focus group discussion with 15 representatives that was held on March 23, 2006 at a hotel in Calgary. Besides those named above from CHR Mental Health and Addictions Services, there were 6 consumer/family member representatives including myself at the table. There was also representation from the Quality Health Improvement and Safety from within Mental Health and Addictions as well as the corporate Regional Patient Safety, Patient Experience, Calgary Health Region. Of note, the Mental Health and Addictions Ethics Coordinator also participated.

This focus group was conceptualized as the initiation of a process of discussion among the various stakeholders towards a renewed emphasis on patient safety in mental health. The commitment to consumer and family representation and involvement was seen as a core element to this process. The articulated goal was also to build an improved mental health care system that ascribed to the principles and intent of the new safety framework & policies of the Calgary Health Region.
There were three objectives set for the focus group discussion:

- To inform the program of safety priorities in Mental Health and Addictions Services
- To recommend improvement indicators
- To suggest key principles and processes for collaborative consumer/family involvement in safety planning and service evaluation

The group discussion was introduced with background information on the Patients for Patient Safety component of the WHO Global Patient Safety Strategy. There followed an intense, multi-faceted two hour discussion reflecting the passion of many of the participants and the inherent complexity of patient safety in the context of mental health and addictions service delivery. The representatives requested a progress update in six months and there is a commitment to provide this.

A summary of the Process Notes including Priorities and Improvements was subsequently distributed to all the participants for feedback. These internal notes will be used to shape planning and strategies in patient safety. They are to be coupled with information coming from existing processes such as Safety Event Review Recommendations, Program Evaluations, Consumer Concerns, Accreditation, and Patient/Staff Satisfaction Surveys.

The concepts and language of patient safety have yet to be well documented for mental healthcare in Canada. Professional and patient constituencies are just beginning to consider patient safety in mental health. This initiative represents a courageous and innovative exploratory attempt in that direction. To my knowledge, there are few, if any, endeavours like it happening in Canadian mental healthcare. I felt extremely honoured to be included.

The focus group discussion was one of my first activities as the Chair for Mental Health with the Patients for Patient Safety Canada group. I wish to take this opportunity to thank Calgary Mental Health and Addictions Services for including me in this initiative. As a consumer, I feel that their openness to new ideas and the inclusiveness with which they are embarking into new ways of practice are extremely gratifying.

For further information contact:
Darrell Horn amitofu@shaw.ca
Dr. Michael Trew Michael.Trew@CalgaryHealthRegion.ca
Francine Chisholm chisholmcrest@yahoo.ca

# WORLD ALLIANCE FOR PATIENT SAFETY

## Patient Experiences: A Call for Stories

- Gillian Perkins, World Alliance for Patient Safety

There are on-going world-wide discussions around implementing patient-centred, systems-based healthcare. The voice of the patients and families who have suffered preventable medical error is a powerful motivational force for healthcare providers across the globe and is an essential and integral part of the work of the World Alliance for Patient Safety. Collecting and disseminating the stories and experiences of these patients and families encourages awareness raising and advocacy which is so vital to changing culture and improving the safety of healthcare. Patients offer a vital perspective.

Sometimes stories are concerned with how patients handle and react to their treatments at other times with how a medical error has led to a greater understanding of how to prevent harm. These stories and experiences when shared inform and influence global policy makers to the value of patient engagement.

The World Alliance for Patient Safety would like to capture some of the unwritten and unspoken stories of ordinary people; people who have experienced an adverse event either themselves or a family member. In particular hearing experiences in developing and transitional countries is important as there is little direct information from patients in these areas.

If you feel able to share your story with the World Alliance team we would love to hear from you. We would require the information outlined below:

Once your story has been collected *the Alliance* will seek to gather independent verification of this through a coroners report, health service report, outcome of any official investigation or finalized legal proceedings. We are happy to contact such parties on your behalf but would need your permission to do so.

**Required Information:**

- Personal details (age, sex, location, name if acceptable)
- Any relevant health history
- Details of the incident where the error or harm occurred
- Impact on your health and personal life (also impact on family and career if appropriate)
- Any insights as to why the incident occurred
- Photo of the patient and permission given for reproduction in a variety of media and formats
- Permission for this information to be used and shared as part of training and awareness-raising by the WHO World Alliance for Patient Safety and selected partners
- Contact details for patient and/or liaison representative

**Your story could be used for a variety of purposes:**

- *Advocacy* – develop the story into a tool for use by Alliance staff, our partners and key collaborators in order to campaign for safer care worldwide.
- *Sir Liam Donaldson, the Alliance Chair's, presentations worldwide* – These are high profile and receive a great deal of interest. Stories used by Sir Liam are very powerful in getting across the importance and urgency of the patient safety agenda
- *Spreading awareness of unsafe care worldwide*
- *Promoting healing and reconciliation by allowing patients' and family members' voices to be heard*
- *Learning from error and risk* – your story could provide a vital input into research on error and risk to better understand how to improve safety
- *Developing a qualitative methodology for narrative collection*

We are working to improve the safety of medical treatment and would like to record patient stories in order to help us learn from them. We might be able to share stories in the ways outlined above but can not promise to do so for every story we record.

If you are interested or want to find out more about how you can contribute your story of preventable medical error to the work of the World Alliance for Patient Safety and it's on-going efforts to make healthcare safer worldwide, please contact Gillian Perkins at Gillian.Perkins@dh.gsi.gov.uk or by calling her on +44 (0)20 7210 4955.

## NGO session on Patient Safety at the World Health Assembly

- Kristine Stave, Partnership Development Officer, WHO Office for Patient Safety, London

The international healthcare and patient safety agenda is often focused on the Governmental perspective, in particular that of Ministries of Health, sometimes to the exclusion of other groups. To remedy this and ensure dialogue with all stakeholders working in this area, the World Alliance for Patient Safety together with Save the Children UK and the International Alliance of Patients Organizations (IAPO) arranged an informal session on patient safety during this year's WHO World Health Assembly.

This roundtable session looked at the issues surrounding healthcare safety from the viewpoint of patients & consumers both locally and at a strategic level, non-governmental organizations delivering care and the clinical workforce.

Jo Harkness from IAPO talked about the importance of patient engagement in healthcare at a strategic level, while Hussain Jafri, the Patients for Patient Safety Champion in Pakistan, described his experience of setting up patient safety initiatives in that country. The clinical workforce was represented by Tana Wuliji from the International Pharmaceutical Federation and Jeff Mecaskey, Head of Health at Save the Children UK talked about the perspectives of non-governmental organizations.

The World Alliance for Patient Safety was represented by Julie Storr, the Project Manager for the First Global Patient Safety Challenge Clean Care is Safer Care, who gave an update of the work of the Challenge in the six pilot sites throughout the world.

Following short presentations by each of the five speakers, questions were taken from the floor. There was a good discussion around the topics of partnership, the perceptions and attitudes which might prevent professionals from welcoming patient engagement and the need to move forward in this area in a collaborative way. New lines of communications were opened between civil society organizations and the World Alliance for Patient Safety, and the Alliance looks forward to progressing our work with these stakeholders.

## Launch of the first nine Patient Safety Solutions

- Susan Sheridan, Chair Patients for Patient Safety

Margaret Murphy and Sue Sheridan PFPS Champions attended the second international solutions meeting on April 4-5, 2007 hosted by Joint Commission International, the WHO Collaborating Center for Patient Safety (Solutions). The first round of international solutions were approved and were then launched on May 2 in Washington DC, USA. They included:

1. Look-Alike, Sound-Alike Medication Names
2. Patient Identification
3. Communication During Patient Hand-Overs
4. Performance of Correct Procedure at Correct Body Site
5. Control of Concentrated Electrolyte Solutions
6. Assuring Medication Accuracy at Transitions in Care
7. Avoiding Catheter and Tubing Mis-connections
8. Single Use of Injection Devices
9. Improved Hand Hygiene to prevent Health Care Associated Infection

For further details and how to access the 9 new solutions electronically, please go to:
http://www.who.int/patientsafety/events/07/02_05_2007/en/index.html

At the April meeting a second round of solutions were proposed to be developed and announced next year which included:

Follow-up on Critical Test Results
Patient Falls
Healthcare Associated Infections – Central Lines
Pressure Ulcers
Response to the Deteriorating Patient
Patient and Family Involvement
Apology and Disclosure
Look-alike, Sound-alike Medication Packaging

PFPS agreed to take the lead on the development of the patient engagement/involvement solution.

## Patient Perspectives in Research

- Sue Sheridan, Chair Patients for Patient Safety

Susan Sheridan, PFPS Champion, attended the May 1 2007 World Alliance for Patient Safety Research Advisory Council Meeting. The agenda items included:

- Current knowledge in patient safety and implications for research
- Research priorities for research on patient safety
- Inventory of methods for patient safety research
- Strategies for increasing capacity in developing countries
- Prevalence of adverse events in developing countries: EMRO, AFRO and PAHO

Patients for Patient Safety submitted for consideration the following potential patient oriented research questions:

***General Research Questions:***
Is the research agenda developed by the WHO aligned with what global patients would request?

***Costs of Medical Error:***
What are the direct and indirect costs of medical error to patients and families?
What are the direct and indirect costs of medical error to employers of patients or families affected?
What are the direct and indirect costs of medical error to the public health and welfare system?
What is the correlation between experience of medical error by a patient or family member and subsequent experiences of depression, mental illness, drug abuse or divorce?

***Reporting***
Are consumers more likely to report medial errors than providers?
What are the kinds of errors that consumers will frequently report?
What kinds of errors are consumers more likely than providers to report?
Do patients and families actively engaged in reporting systems contribute to achieving better treatment outcomes for themselves or others?
Does increased patient reporting impact the frequency of litigation or compensation claims?
What kinds of redress do patients who report seek? Is it different from what patients who litigate seek?
Do patients have different needs, e.g. the need to report in a narrative format, than providers?
Do patients who report need feedback from a learning/reporting system in order to sustain their interest in contributing to it?
Do patients who report medical errors experience a decrease in anger, depression, alcohol use, divorce or other measures of distress?

***Patient Education***
What types of patient education materials are effective in engaging patients to be more involved?
What are the most effective ways to communicate risk?
What is the most effective way to change patient/consumer behaviour regarding risk? Does generating fear of consequences play a role in changing behaviour?
Do patients who have experienced medical error provide a unique resource and an acute 'safety perspective' in root cause analysis, the creation of patient safety solutions, patient education materials, campaigns, focus groups, advisory boards etc. as opposed to patients who have not experienced a medical error.

***Patient Advisory Boards***
Are patient advisory boards effective in creating better patient safety outcomes in healthcare?
Does the establishment of patient advisory board expedite the adoption of programmes designed to reduce risk, increase clinician awareness of safety risks, or change behaviours among clinicians?
Does the establishment of patient advisory boards increase rates of disclosure or medical error? Rates of apology? Willingness of personnel within a healthcare system to openly and honestly discuss medical error?
Is there a correlation between establishment of a patient advisory board and changed patient/family behaviours during treatment?
Does the establishment of patient advisory boards increase public trust?
Does the establishment of patient advisory boards decrease medical malpractice litigation?
Do patients who participate in organized patient activity experience a decrease in anger, depression, alcohol use, divorce or other measures of distress?

PFPS invites all Champions and interested parties to submit other additional patient oriented research topics to continue to integrate patient centered research opportunities into the World Alliance for Patient Safety Research strand.



*Editor: Rachel Heath, Patients for Patient Safety Project Manager*
safety@patientsorganizations.org

# Other Patient Safety and Patient Involvement News

## Europeans for Medical Progress Trust launches short film "Safer Medicines"

"Right now, researchers are trying to bring 21st-century medical innovations to market using 20th-century tools to evaluate them." US Food & Drug Administration, 2006.

On Wednesday 25th April patient safety charity Europeans for Medical Progress Trust launched their new film, Safer Medicines, at a reception in the House of Commons hosted by the Rt Hon Tony Benn.

The Northwick Park clinical trial disaster early last year starkly illustrated the problems faced by people taking a new drug for the first time. More broadly, a quarter of a million hospital admissions each year are due to side effects from prescription medicines (British Medical Association report, May 2006). Safer Medicines brings together world-leading scientists from industry & academia to present their vision for the future of drug safety testing, and showcases the latest technologies now available, from microdosing and human tissues to gene chips and computer models. Science is constantly evolving, and this ground-breaking film introduces the latest thinking and addresses the question of how best to bring our medical regulations up to date to cope with the challenges posed by 21st century drugs.

The film can be viewed free of charge at www.curedisease.net/safermedicines/ and DVDs are available free of charge to schools and universities. Please email info@curedisease.net for more information.

## National Patient Safety Foundation Annual Conference

The 2007 Congress took place in Washington DC on 2-4 May with the theme "Learning from the past, creating the future".

The NPSF Congress is the largest convenor in the world of an event solely dedicated to enhancing patient safety and over 1500 people took part in this event. The Congress presented successful strategies for promoting patient safety across the continuum of the healthcare system and there were a range of plenary sessions and workshops which highlighted effective implementations of policies and programs that result in cultural change and sustained improvement processes toward a safer environment.

An international flavour was ensured by the presence of the WHO World Alliance for Patient Safety: The Alliance had a stand at the Congress, presented a poster on the achievements of the First Global Patient Safety Challenge *Clean Care is Safer Care*, provided input to the Congress' Distinguished Advisors Plenary through its Chair, Sir Liam Donaldson, and held a plenary session on 4 May to present its work over the last 12 months.

## News Highlights!

### *Ukraine*

In Kiev on 1-3 June Vasyl Kvarituk, *Patients for Patient Safety Champion* held an In-country Patients for Patient Safety Workshop with his organization, All-Ukrainian Council for Patients' Rights and Security. Margaret Murphy from the PFPS Steering Group attended along with fellow *Patients for Patient Safety Champion* Jolanta Bilinska from Poland and there were 16 patients from across the country who came together to share their experiences and thoughts on patient safety issues and the role of patients in the Ukraine. We look forward to hearing more from Vasyl in the next edition.

### *Patient Safety Trek in Pakistan!*

Two Patients for Patient Safety Champions, Jolanta Bilinska (Poland) and Hussain Jafri (Pakistan) are about to undertake a trek to the Base Camp of Nanga Parbat Mountain in Pakistan to raise awareness for Patient Safety issues and build collaboration between their two organizations, Patient Safety Foundation for Poland and the Pakistan Patient Safety Initiative. The Polish team will meet with representatives from the Ministry of Health in Pakistan, address a press conference and visit a hospital and a school. It is hoped that in the future the Pakistani team will visit Poland to meet with key policy makers and patient rights organizations there to build partnerships and share experiences.

We wish both Hussain and Jolanta all the best for a safe and fruitful trek and look forward to hearing all about it on their return.

### *New support group for mothers in Mexico*

Sue Sheridan, Chair of Patients for Patient Safety and also co-founder of Parents of Children and Infants with Kernicterus (PICK) recently visited Evangelina Vasquez Curiel a *Patients for Patient Safety Champion* in Mexico to establish and build collaboration between PICK and Evangelina's recently formed group to help create awareness in Mexico on the dangers of jaundice and support families with children who have also suffered from Kernicterus.

## Useful Information and Resource Sites

- ***Agency for Healthcare Research and Quality***
  www.ahrq.gov (see: their patient and consumer section)
- ***Institute for Healthcare Improvement***
  www.ihi.org (see: their patient-centered care section)
- ***Manitoba Institute for Patient Safety***
  www.safetoask.ca (speak up campaign)
- ***National Patient Safety Foundation:***
  www.npsf.org
- ***NHS Centre for Involvement***
  www.nhscentreforinvolvement.nhs.uk

EMRO Patients for Patient Safety Workshop, Cairo 26-28 March 2007

**Don't forget to visit our website at:**
http://www.who.int/patientsafety/patients_for_patient


*Editor: Rachel Heath, Patients for Patient Safety Project Manager*
*safety@patientsorganizations.org*