



**World Health
Organization**

REGIONAL OFFICE FOR **Europe**

Patients' Safety:

**2nd Round table on
Reporting systems in health care**

**28 – 29 November 2011
Bratislava, Slovakia**

ABSTRACT

The Second round table on reporting systems in health care, which was held in Bratislava, Slovakia, on the 28 and 29 November 2011, was an opportunity for representatives of the Czech Republic, Slovakia and Slovenia to monitor the progress made in the area of patient safety since the First round table a year earlier. It was also an opportunity to learn from each other experiences and from those of other international participants. Current issues and achievements were explored among others with regards to adverse events reporting systems and research in health related harm. The importance of patient engagement and education of healthcare workers on patient safety has been stressed again. The opportunities to tackle patient safety through integrated approaches were explored, while the importance of networking of all stakeholders nationally and internationally was recognized. A set of further recommendations was developed, including continuing to meet at patient safety round tables.

Keywords

PATIENT SAFETY
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Introduction

The second round table on reporting systems in health care was organized by the World Health Organization Regional Office for Europe (WHO Europe) and supported by the Ministry of Health of Slovakia, as a multi-country event. It took place in Bratislava between the 28 and 29 November 2011.

The event was a follow up to the First round table on the same subject that took place in Ljubljana between the 29 September and 1 October 2010. The Second round table was attended by representatives of the Czech Republic, Slovakia and Slovenia. The participants were experts from ministries of health, national competent authorities for supervision in healthcare, representatives of healthcare organizations, patient organizations and other stakeholders from the abovementioned, other European countries and WHO.

The objectives of the meeting were to report on intervention in patient safety that took place in participating countries in the time lapsed since the First round table, share the results of research aimed at measuring healthcare related harm, use the latest evidence and international experience to improve patient safety in general and reporting mechanisms in particular. The meeting also offered a platform for discussion and strengthening the collaboration among participating countries in support and promotion of an approach that involves all the stakeholders.

The Second round table took place at a time of intense preparation of the new European Health Policy – Health 2020. The policy builds on the principles of the Tallinn Charter: Health Systems for Health and Wealth. It promotes health equity in all policies and an integrated approach for improving health and wellbeing, including patient and consumer protection and safety.

The meeting was opened by Dr. Mario Mikloši, Director General, Health Section at the Ministry of Health of Slovakia, who stressed the importance of patient safety and its position as a priority on the agenda of the Ministry of Health.

Dr. Peter Bandura, national coordinator for patient safety in the Slovakia agreed to act as chair to the meeting. The reporter of the event was Dr. Mircha Poldrugovac, Slovenia.

Country progress: an overview

Through various presentations given in the course of the Second round table and ensuing discussions, a picture of the state of the art in the area of patient safety and progress made in the past year can be drawn for each participating country.

The Czech Republic

The Czech Ministry of Health recognized several strategic steps to be taken in order to improve quality and safety of healthcare services. The key areas identified included embedding of quality and safety assessment of healthcare services in legislation, implementation of patient safety programmes and strengthening of cooperation among stakeholders and the creation of healthcare quality standards and indicators. A number of activities are already under way in order to achieve these goals.

Starting in 2012 the Act on Healthcare Services and the Conditions for Their Provision will include obligations for providers of risk procedures to perform quality and safety assessment of the services. The aim is to increase transparency and accountability for monitoring quality and safety through an appropriate legal framework. As the changes have been introduced very recently, it is too early to report on their impact on healthcare service delivery.

The Czech Ministry of Health also established an information portal on quality and safety in healthcare, in order to offer a comprehensive information resource. The portal is aimed both at healthcare professionals and at the general public. A noteworthy publication available on the site is the Patient Safety Book. The Book contains recommendations on improving patient safety with separate sections for patients and healthcare workers.

The Ministry of Health also entrusted the Public Health Department of the 3rd Faculty of Medicine at Charles University in Prague to pilot the establishment of an adverse event reporting system for providers of healthcare services. The system expanded significantly in the past year, more than doubling the number of participating hospitals. As of November 2011 there were 50 hospitals, representing approximately 40 % of bed capacities in the Czech Republic participating to the system. The Ministry of Health was active in ensuring participation of publicly owned hospitals; however it does not have access to the data hospitals report to the Public Health Department that administrates the system. Reports are created mainly for benchmarking to the advantage of participating healthcare provider organizations. The identity of the single hospital is encoded in the report, so that only authorized personnel from the relevant organizations receive the code that identifies their own results. The system does not replace the various mechanisms of vigilance already in place in various areas. However efforts are underway to adapt the reporting system, so that all necessary incident reports in all patient safety areas can be made using the same application. Harmful events concerning health care workers, although not seen strictly a patient safety issue, have been included in the system.

Reporting of adverse events in primary health care requires a different approach. Such a system needs to take into account the extremely high rate of individual general practitioners, who have a contract to provide services within the public healthcare system. Such practitioners have reservations about sharing their weaknesses, which is seen as giving up part of the autonomy that has been granted to them. The establishment of an accreditation programme in primary health care is seen as a useful tool to support adverse event reporting. The accreditation standards include a requirement regarding critical incidents and errors reporting. The establishment of a structure for incident reporting has been piloted through 2010 and 2011 among a few general practitioners. The project provides the basis for establishing a strong reporting and learning culture in the future.

Slovakia

Creating networks and strengthening collaboration between stakeholders in the area of patient safety is crucial in the health care system of Slovakia. Many hospitals have implemented systems for quality improvement and patient safety, however a comprehensive overview of these activities at the national level is currently lacking. Plans are already in place not only to gather information in this field, but also to disseminate them and foster sharing of practical solutions implemented by healthcare provider organization. Enhancing quality and patient safety through an integrated approach and by supporting networks involving all stakeholders is also one of the

aims of the Biennial Collaborative Agreement between WHO and the Slovakian Ministry of Health.

The existing legislation lays down requirements for transparent allocation of organizational responsibilities defined in several acts. In particular a Methodological Guidance in the field defines patient safety, patient safety culture, adverse event and sets a classification framework. The Methodological Guidance also establishes reporting systems in hospitals and gives guidance for the prevention of adverse events.

Hospitals submit reports on adverse events to the Health Care Surveillance Authority (HCSA). HCSA is an independent entity which closely collaborates with both the Ministry of Health and the Ministry of Finance. It has supervising responsibilities over provision of health care services, purchase of those services and over activities of health insurance companies. Part of the patient safety reporting systems is however based on voluntary participation by hospitals. HCSA noticed a reduction in the number of adverse events reported by hospitals through the years 2007 - 2009. For this reason a serious effort was required to enhance interest and improve communication with hospital leaders. As a result of these efforts the number of adverse events reported increased significantly in 2010. Interestingly the marked increase in the number of reports can be ascribed mostly to physicians.

In 2011 HCSA with the approval of the Ministry of Health and in partnership with 5 university hospitals and the OECD Health Division performed an analysis of patient safety in the hospitals included in the project. Several experts from the abovementioned institutions participated to several education and learning meetings. The aim is to recognize the main issues in the area of patient safety, and with the help of OECD experts evaluate the possibilities to monitor those areas, particularly by using specific indicators.

A survey on adverse events using the WHO methodology on tackling patient harm was carried out in 2011. The survey included four hospitals and included the review of 450 records. Adverse events were found in 14,67% of reviewed cases. Interestingly 26% of adverse events have occurred outside hospitals. Among all the adverse events found 58% were deemed to be more likely preventable and in an additional 14% of cases there was strong evidence of preventability. The results of the survey are expected to inspire new policies for the improvement of patient safety.

Slovenia

Several activities took place in Slovenia in view of initiating a similar research on the frequency of adverse events in healthcare. Eleven hospitals including both University medical clinics agreed to participate to the survey. Those hospitals were responsible for 68% of all discharged patients according to 2009 data. The protocol chosen for the study is the record review of current inpatients aided by interviews with staff. Training for investigators lead by WHO experts took place in January 2011 and a specific study protocol (similar with the one applied in Slovakia) was submitted to and approved by the National Medical Ethics Committee. The protocol included a requirement of patient consent in order to review their records, which was seen as a potential threat to the success of the study, given the sensitivity of the subject. Consequently with the aid of the Information Commissioner in Slovenia (the authority supervising the implementation of provisions related to personal data protection), a compromise solution was identified as implementing the survey in the form of internal audit. Agreements will be signed

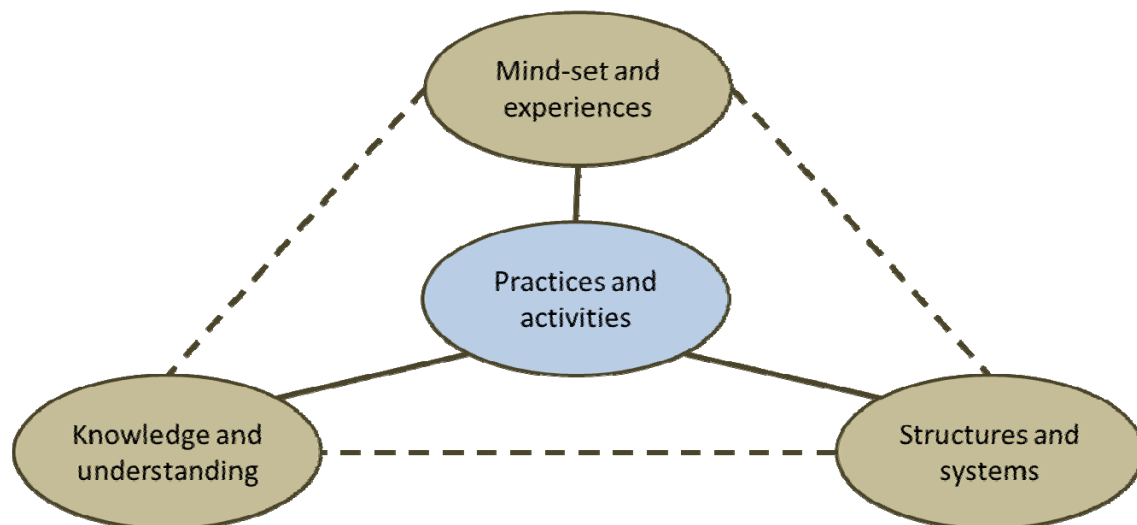
with participating hospitals, investigators and the Ministry of Health in order to insure the appropriate level of confidentiality and personal data protection. As the Ministry of Health is the main sponsor of the survey and since strict limitations apply to all budgetary spending the agreements were still pending at the time of the event.

In the mean time, the Ministry of Health sponsored a survey on patient safety culture using the United States Agency for Healthcare Research and Quality, piloted in three hospitals. A plan for a comprehensive evaluation of patient safety culture was established at the beginning of 2011. Half of all Slovene hospitals have already been surveyed, with the other half expected to be surveyed in 2012.

Integrated approaches

Several factors greatly influence practices and activities in the area of patient safety. The interplay of three key factors and their influence on practice is the basis for a model used in some Finnish hospitals. This can be applied more broadly as an interpretative framework for an integrated approach to improving patient safety. The scheme has been reproduced in Fig. 1.

Fig. 1 Interplay of factors expected to improve patient safety



Source: adapted from dr. Teemu Reiman presentation

The importance of and need for a patient safety culture has been widely recognized, this being in close relationship with the application of patient safety practices. The sensitivity and fear related to reporting of failure needs to be overcome. This requires an updated regulatory framework supporting the engagement of health care workers, and the development and use of dedicated guidance and tools influencing on a short and long term patient safety practices.

An example of such a regulatory framework is the new Finnish Healthcare Act which requires organization to develop a plan for quality and patient safety actions. Also in this case it appears that the effectiveness of the provision depends on the general cultural context in which it is used. The latter can make a difference between a plan prepared merely in order to satisfy a legal requirement and a plan that reflects a genuine effort to improve quality and patient safety in an

organization. Similarly the adverse event reporting system in Slovakia has been characterized as playing a role that may range from statistical gathering of data to being an important factor in patient safety improvement. The noteworthy increase in the number of adverse events reported within this system in 2010, mentioned earlier, points to the extent to which awareness rising and supporting engagement can influence the success of the system.

Upgrading knowledge can be done through both undergraduate and postgraduate education as well as in the form of continuous professional training. While patient safety is developing as a science in its own right, health professionals' curricula are mainly centred on the development of clinical skills. In this respect, the WHO multi-professional patient safety curriculum was launched in 2011. Work on its promotion with higher education institutions is in process and it has been already included in the training curricula of several Universities. Inclusion of patient safety topics in postgraduate training or medical specialization is expected to enhance its impact on patient safety practice.

Providing contents in the area of patient safety within the formal framework of undergraduate and post graduate education is a significant challenge. A complementary approach is to disseminate useful tools and make information available in order to raise awareness and promote engagement of both patients and healthcare workers. The Patient Safety Book prepared in the Czech Republic was already mentioned. A number of other tools are also available, for instance a patient safety management model used in Finland and many useful publications prepared by the Danish Society for patient safety, which have been translated in English and are freely available on the website. All available tools for education and training need a structural and cultural context in which to be used and implemented.

The role of patients

The important role of patients in strengthening health care has been already recognized and documented. The WHO Patients' for Patient Safety direction of work has been promoting through its patient champions and sustained work on patient engagement, shared decision making and supportive dialogue between the patient and the health care provider. Patient safety champions intensely advocated these topics in many countries around the world. Numerous information and educational materials instructing patients on how they can contribute to improved care and self disease management have been developed, and such publications were reported by the countries participating in the event. Particular attention has been drawn to the patient reporting system introduced in Denmark and the number of issues to be considered before such a system can be established: risks of massive reporting and legal implications related to confidentiality of data.

There are many ways to involve patients in patient safety activities however the fundamental common denominator remains a change of perspective on the role of the patient as co-producer of healthcare. The increasing 'activation' of the patient is not expected to represent a shift of responsibilities from the health care workers, and it is important to note that common barriers apply when trying to increase communication and shared decision making for both healthcare workers and patients, in this area.

The hospitals' perspective

Health care organizations are complex adaptive systems. Interventions on such systems lead to non-linear effects, so that sometimes apparently small activities lead to significant changes or changes that manifest themselves in the long run. Many hospitals presented their activities for improving patient safety. Supporting the report of adverse events, pressure ulcers, introducing identification bracelets with coloured labels and preoperative protocols are just some examples of such interventions. Because of the characteristics of complex adaptive systems mentioned above, the impact of those changes is sometimes hard to assess, particularly when these represent punctual interventions, lacking a coordinated and comprehensive approach.

The example of developing and implementing a comprehensive patient safety management model in the Vaasa central hospital in Finland, was based on the understanding of patient safety that shifted from the absence of errors to the ability to succeed under constantly varying conditions. This was supported by the introduction of the adverse event reporting system and the Global Trigger tool, and by education of health care workers in the area of patient safety. The strong support of the decision making levels (i.e. hospital management) proved to be a key precondition for the success of this intervention.

The risk managers

The importance and principles of root cause analysis were one of the major topics discussed during the First round table. At one year interval, discussions focused on the practical aspects of how reporting and analysis of adverse events are carried out at the healthcare organization level, as well as how the feedback to reporters can gain and increased benefit.

The person in charge of coordinating activities on adverse events reporting at the hospital level has an important role. This is usually undertaken by the risk manager or patient safety officer. In Denmark, all hospitals have risk managers. In Slovenia, this task is taken over by patient safety officers, identified in all hospitals. It is important to note that according to the system in place, the position can be covered by a dedicated health care professional, or it can come as an addition to their usual responsibilities.

The role of risk managers is particularly demanding. They are usually the key element linking health care workers, who report adverse events, and senior managers, who must not be in a position to initiate disciplinary actions against reporting personnel. Risk managers are also often a contact point for patients, responsible for communication about adverse events and ensuing analyses. Given the specific set of skills required of a risk manager, it is necessary to provide opportunities to risk managers to exchange experiences and advice through a more or less formal dedicated network.

Data protection

The issue of data protection has been debated in particular in relation to adverse event reporting system confidentiality, which is expected on many levels. Health care workers expect that analyses of adverse events will not be made available to patients - an important precondition in order to encourage self-reporting. Systems for managing patient complaints or suspected

malpractice policies include redress mechanisms for patients and are strictly separated from adverse events reporting. The strict protection of reports within the Danish system is an example of provisions embedded in the law. Healthcare organizations are also cautious about the information that is made available to administrators of the national reporting system. In the case of the Czech reporting system, agreements are signed by health care provider organizations and the national administrator, defining the data that is made available to the latter. The fear over potential punitive actions against the reporting health care provider/ health care organization acts often as major limiting factor in the availability of complete data on reported adverse events. In many cases hospital level data may even not be fully available to the competent ministry.

The issue of personal data protection was raised by all participating countries. The challenges tackled in Slovenia in order to perform the survey on the frequency of adverse events in hospitals were mentioned. Similar challenges were also faced in Slovakia in the course of the survey. In the Czech Republic issues about personal data protection were raised in order to allow the national administrator of the adverse event reporting systems, i.e. the Department of Public Health of the 3rd Medical Faculty of Charles University, to offer its information technology infrastructure for reporting to hospitals. In all of those cases several confidentiality agreements needed to be signed, slowing that progress of the envisaged patient safety activities in some cases requires a consolidated level of confidence between all stakeholders involved.

Financial considerations

While the financial crisis in Europe has not been mentioned in the course of the meeting, its impact was partly felt. Limitations on spending from the national budget have temporarily halted the survey on adverse events in Slovenia. Investigating the consequences of unsafe care in terms of costs is also a rapidly developing area of study, as it might motivate the payer to take a more active role in certain cases. A lack of funding is often the stated reason why certain patient safety activities or projects are not carried out. The relevance of these considerations is diminished, if we consider patient safety as the task of reducing harm with whatever is available. Looking at the long term financial gain of reducing failure in health care should represent an additional argument in moving forward the patient safety agenda and supportive interventions.

The way forward: incentives and sustainability

The need for incentives to enhance patient safety interventions, as well as the sustainability and institutionalization of the ones already successfully implemented emerged as a key areas to be addressed.

Looking at incentives, several dimensions were identified: measurement and goal setting, financial incentives and support for patient safety activities through education and empowerment. Monitoring patient safety improvement can become important drivers in health care, by setting objectives and evaluating achievements. An accreditation framework is a clear example of setting standards and evaluating compliance. A softer approach to measurement and goal setting is the use of internationally agreed indicators that provide an opportunity for benchmarking. An example of such an approach is the Performance Assessment Tool for Quality Improvement in Hospitals (PATH) project lead by WHO.

Many initiatives require resources to be carried out. Providing some sort of financial incentive for undertaking patient safety work can prove very helpful in boosting efforts in this area. In Slovenia for instance the Ministry of Health offered to refund hospitals part of the costs of their first external review in order to support accreditation of healthcare provider organizations. The payer of health care services might also be willing to take a more active role in providing financial incentives for patient safety activities. The interest might come also from potential savings coming from a reduction in harm to the patient. Those costs are difficult to evaluate, however various initiatives are under way in this area. WHO in collaboration with Harvard School of Public Health is currently performing a study on the global burden of unsafe care. In Slovenia an evaluation of the costs of adverse events is currently under way. The Danish Society for Patient Safety is mostly financed by the health care fund, which points to a recognized responsibility of the payer, but also poses questions of long term sustainability.

Ensuring sustainability of activities in the area of patient safety is another key issue. In Slovenia for instance a programme aimed at supporting the establishment of clinical guidelines slowly waned as the pilot phase drew to an end. The lesson learned has been to include provisions for long term sustainability in the planning phases of each new initiative. The final aim is usually to institutionalize a change, often bringing amendments to the legislation. The latter take place very slowly and selectively, which could be seen as entering a long term competition.

Institutionalization could be seen as the ultimate goal to ensure long term sustainability of a change, but also the hardest to achieve. One recommendation is to involve all the relevant stakeholders. Networks of professionals sharing similar experience and aims, such as the risk managers' network envisaged by the Danish Society for Patient Safety, can be helpful. Stakeholders also need to keep the efforts in patient safety high on the priority agenda. The commitment in this sense is clear from many institutions and includes the present event, the Joint Action on patient safety and quality of health care within the European Union, but also documents, such as the Biennial Collaborative Agreements signed between WHO and Ministries of Health of its Member States. Identifying leaders and champions is an important step in engaging stakeholders.

It is also crucial to give constant feedback on reports received, as well as guidance for both remedial actions and improved reporting processes. This can be done in the form of protocols and guidelines, by implementing IT user friendly reporting systems, and by publishing information on dedicated web portals. Publicly available information will increase transparency and raise awareness on the magnitude of the issue, as well as the need for concerted field action supporting health care improvement, involving the health care profession, patients, families, and the population at large.

Conclusions and next steps

Based on the discussions and outcomes of the 2nd Round table, several areas for action were identified, with a focus on sustainability, capacity building, and collaboration and information exchange. These are summarized below.

Work towards the institutionalization of patient safety interventions in order to insure sustainability, e.g. by incorporating them in management systems, should be continued. These

are expected to include increased coverage and stakeholder involvement, to support the required cultural change to promote a reporting and learning culture.

The possibility of ensuring a financially stable framework for organizations that have responsibilities in the patient safety area and which sustain the use of important patient safety tools has to be further explored. In this respect, including the evaluation of economic implications and in particular potential for savings should be foreseen when piloting new patient safety interventions, and used as advocacy tools with the payer and the ministries.

Incorporation of patient safety education in the undergraduate and post graduate curriculum for health care professionals should be strongly advocate and promoted. This should include education to communication with patients and team work, as well as patient health education modules that would support increased patient engagement in reducing safety risks, and promote a reporting and learning culture.

The establishment of networks for benchmarking, shared challenges and lessons learned, should be considered at local, national (e.g. through risk managers' networks) and international level (e.g. through the EU Joint action on patient safety and quality of health care), as part of the sustainability, consistency and information updates mechanisms.

Continuation in multi-country mode of already initiated activities is recommended as well as closer partnership and coordination with the starting Joint Action on patient safety and quality of health care and European Commission actions. Further exchange of materials and best practices is important through the establishment of professional networks, patient safety conferences and 6 monthly virtual meetings.

A follow up 3rd Round table meeting is recommend in 1-2 years to continue to monitor progress and benchmark with international experience.

Annex 1. Scope and Purpose

The diversity of health systems across the European region in terms of development, resources and needs, the particular epidemiological profile and the subsequent issues related to national and cross-border care are recognized. Improving patient safety is a core issue for modern health care services and directly contributing to equitable access to care.

Current conceptual thinking on patient safety places prime responsibility on deficiencies in system design, rather than individual providers of care. This reflects the need to develop and strengthen the culture of safety as an integral component of quality in health care.

Although a considerable amount of research is taking place in the field across Europe, there is a need to increase the leaning about what interventions really add value in terms of changing culture, practices, processes and regulatory frameworks to improve patient safety. It is a known fact that 10% of hospital admissions still incur some kind of serious harm, and that over 50% of these are preventable. Patient safety can raise concerns also outside the hospital setting, in general practice, pharmacies and the community. The cost of serious safety errors is counted both in human suffering for patients, their families and health professionals, as well as the financial costs incurred to health care.

The present meeting is a follow up on the multi-country initiative involving Czech Republic, Slovakia and Slovenia started in 2010. It aims to further explore local experience related to preventable harm, and supportive monitoring mechanisms, including the feasibility of integrating reporting systems and to further identify common lines for interventions required to consolidate collaborative patient safety work.

The objectives of the event are to:

1. To strengthen the common platform for discussion and information exchange between participant countries, and share results of local dedicated research in measuring/preventing health care related harm and efficiency of alert mechanisms;
2. To report on status of planned interventions at one year time from inception, including focus on health promotion and patient safety engagement/ health literacy at various levels of health service delivery;
3. To use latest evidence, international experience and national data and know how to increase efficiency of existing reporting mechanisms and further develop updated milestones for action.
4. To enhance ongoing communication, by bridging initiatives and projects for patient safety, enhance patient and consumer involvement and consolidate multi-stakeholder approaches for patient safety at local, national and regional levels

Annex 2. Provisional Programme

Monday 28 November

08:30 – 09:00	<i>Registration</i>	
09:00 – 09:20	Opening address	Representative of the Ministry of Health of Slovakia
09:20 – 9:50	Objectives of the workshop Election of chair and reporter Introduction and expectations of participants	
9:50-10:10	Building a new European Health Policy and its reflection in the biennial collaborative agreement field outcomes	Dr. Darina Sedláková
10:10-10:40	Patient engagement in reducing health care associated safety risks	Dr. Valentina Hafner
10:40 – 11:10	<i>Coffee break</i>	
11:10 – 13:00	Progress on patient safety initiatives in quantifying and addressing the magnitude of health care related harm	Dr. Carmen Audera Lopez
	Review of patient safety management systems	Dr. Teemu Reiman
	Danish experience in patient safety improvement strategies	Dr. Hans Trier
	Discussion	
13:00 – 14:00	<i>Lunch</i>	
14:00 – 15:30	Round table on building patient safety culture – country experiences - Patient safety activities in Slovakia - Incorporating patient safety in the Czech legislation - Patient safety culture in Slovene hospitals (pilot study)	<i>Facilitator:</i> T. Reiman (10') <i>Panel: (discussion 20')</i> - E. Nagy (SVK) 20' - M. Kalvachova (CZH) 20' - A. Robida (SVN) 20'
15:30 – 16:00	<i>Coffee break</i>	
16:00 – 17:30	Round table on measuring health care related harm - Patient safety research in Slovenia – preparatory process - Retrospective record review of inpatient care in Slovakia - Patient safety in primary care in the Czech republic	<i>Facilitator:</i> C. Audera (10') <i>Panel: (discussion 20')</i> - M. Poldrugovac (SVN) 20' - P. Bandura (SVK) 20' - B. Seifert (CZH) 20'
17:30 – 18:00	Preliminary conclusions and closure of day 1	

Tuesday 29 November

09:00 – 09:30	Building capacity to prevent health care related harm: WHO patient safety multidisciplinary curriculum	Dr. Carmen Audera Lopez
09:30 – 10:45	Round table on hospital reporting systems - Reporting systems on adverse events in Slovak hospitals - Reporting systems on adverse events in Czech hospitals	<i>Facilitator:</i> Dr. H. Trier (10') <i>Panel: (discussion 25')</i> - J. Gajdoš (SVK) 20' - P. Hrib (CZH) 20'
10:45 – 11:00	<i>Coffee break</i>	
11:00 – 12:30	Case studies from Slovak hospitals - Prevention of central venous catheter related infections in Novo Mesto General Hospital - Patient safety activities to prevent adverse events in the University Hospital Banska Bystrica - Prevention of bedsores in University Hospital Bratislava - Patient safety mechanisms in the Faculty Hospital Presov	<i>Facilitator:</i> D. Sedlakova <i>Panel: (discussion 20')</i> - L. Kosec 15' - B. Sepesi 15' - E. Nagy 15' - P. Bandura 15'
12:30 – 13:30	<i>Lunch</i>	
13:30 – 15:00	Round table discussion on developing and implementing effective learning and reporting systems, supported by national patient safety network	All participants
15:00 – 15:30	Conclusions and recommendations	
15:30 – 16:00	Closure of the meeting	

Annex 3. List of Participants

Country representatives

Slovakia

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