



**World Health
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Report on
WHO multi-country workshop on
patient safety reporting and
learning processes and networks

23rd -24th September, 2013
Krakow, Poland

ABSTRACT

The multi country workshop, organized in collaboration with the WHO global patient safety programme, and hosted by the WHO Collaborating Centre for Quality of Care and Patient Safety Krakow, aimed at monitoring progress and strengthening information exchange in patient safety, within the participating countries. The work has been covered by biennial collaborative agreements, with a particular focus on patient safety centred care. The role of reporting and learning processes and the importance of human factors in the epidemiology of safety in medicine were seen as key issues in improving quality and safety of care. The experience of safe management systems shared is expected to involve further expansion of existing national networks and stakeholders.

Keywords

ACCOUNTABILITY
COLLABORATION
PATIENT PARTICIPATION
PATIENT SAFETY
QUALITY OF CARE
SAFETY MANAGEMENT

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Introduction

‘Health 2020’, the guiding European health policy document, calls attention to health system strengthening (HSS), prioritizing efforts to ensure health systems are people-centred, high quality and fit for purpose in the context of the 21st century.

In the existing financial and organizational environment of modern health services pressured to respond to escalating demands for care (aging populations, increasing prevalence of chronic and multiple conditions) there is a renewed emphasis on high quality performance and patient safety. Within this context, patient safety principles and concepts apply irrespective of the place where health care is delivered, the type of health care provider, and the type of patient, playing an important role in strengthening health care systems.

A shortage of practical evidence however fuels the current challenge for improving safety of services at the system level. To cover the gap, reporting systems aimed at learning and further mitigating and preventing the occurrence of errors in health care have been developed, and experience shared through regional networks and global initiatives. There is an identified need for active risk assessment mechanisms that analyze and quantify the magnitude of potential generated health care related harm, and support the development of safety management thinking. Engaging health professionals and empowering people (citizens, consumers and patients) are seen as critical factors in improving health outcomes.

The multi country workshop, organized in close collaboration with the WHO global patient safety team and the WHO Country Office Poland, was hosted by the WHO Collaborating Centre for Quality of Care and Patient Safety Krakow. This workshop aimed to:

- Increase awareness and improve knowledge with respect to the latest patient safety concepts and generic interventions,
- Present core principles around quality improvement and safety management in health care, including the role of effective communication and monitoring mechanisms,
- Provide a platform for shared experience and information exchange, including success stories and challenges in participating countries in the field of patient safety
- Enhance coordination mechanisms with existing networks and further foster collaborative exercises with European stakeholders.

It brought around the table national experts in quality of care and patient safety from Czech Republic, Poland, Slovakia and Slovenia, supported by further international expertise.

The event was opened by Dr Anna Lesniewska, representing the Ministry of Health, who welcomed participants and underlined the important place that quality and safety of care have on the national health agenda. Dr. Jerzy Hennig leading the WHOCC National Centre for Quality assessment highlighted the work on patient safety and quality of care done by the WHOCC, as part of national endeavours and international collaborative exercises. Dr. Paulina Miskiewicz, Head of WHO Country Office in Poland emphasized the role of the multi country event as part of reporting on the implementation of biennial collaborative agreements for patient safety and the part information exchange and shared experiences play in capitalizing on success stories and evidence in strengthening health services.

During the two days workshop, participant countries reported on progress in the field, and updates in the field of human factors, system and patient safety were presented. For the purpose of giving consistency to country updates in the report, the subjects addressed have been

regrouped under: general topics, country reviews, and round table discussions, conclusions and recommendations calling for innovative approaches across core health system functions. The report of the meeting was compiled by Dr S. Burnett, and Dr B. Kutryba.

General topics discussed

Patient safety and patient centred care

The commitment to better health and health system strengthening, put forward in 2008 with the Tallinn charter for health and wealth, was recently reiterated during the High level event Tallinn, October 2013) monitoring progress achieved in the charter's implementation.

The roadmap for coordinated integrated health service delivery launched draws on the management and delivery of health services such that people receive a continuum of service through different levels and sites of care within the health system and according to their needs.

Advancing patient safety interventions has become a priority in the campaign to strengthen health systems. This follows the declarations in Luxembourg, London, Warsaw and Helsinki where governments as well as associations of patients and health care professionals across Europe allied to make patient safety a priority. As such, patient safety plays an important role in the development and implementation of people centred care, with the aim to make all treatment appropriate and safe with patient participation and contribute to improve system performance and reduce errors. The 12 WHO global strategies and tools for patient safety include: clean care is safer care addressing health care-associated infection, through hand hygiene; safe surgery saves lives for safe surgical practices; safe childbirth checklist promoting safe practices during pregnancy and childbirth; partnerships for patient safety; safer primary care tools; compilation of best practices and knowledge management on patient safety; standardized patient safety protocols; patient safety education and training for health-care professionals, academics and students; patients for patient safety creating effective partnerships between patients and the health care community; medication safety and injection safety. Two new launches are planned for 2014: the WHO initiative on injection safety under DG mandate to promote rational and safe use of injections, and the 3rd patient safety challenge on medication safety.

Health 2020, the new long term European policy, aims to address major health challenges, investing in health through life course, strengthening health systems and creating a supportive environment - adding value through partnership.

The discussion that followed included the need to change medical culture and educate patients to take responsibility for their own health and the safety of their care too. The need for funding for patient safety was raised and the European Health Observatory Report on financial pressures in different European countries was considering for further reading.

Human Factors

Human factors describe the relationship between people, the environment and technology. As defined by WHO, human factors refer to environmental, organizational and job factors, and human and individual characteristics which influence behaviour at work in a way which can affect health and safety.

Aviation has been applying the science of human factors for over 30 years to reduce airline accidents, with all pilots trained in human factors. A very good example is the acronym HALT: 'HALT: Hungry? Angry? Late? Tired? – don't fly a plane if any apply'

Aspects of human factors include:

1. The individual: competence; skills; personality; fatigue; illness; vision and hearing problems.
2. The task: workload; procedures; tools; noise etc
3. The organization: leadership; administration; management; policies etc.

The areas where human factors have been applied to reduce errors in health care include the design of IV pumps and the layout of wards, laboratories and operating rooms.

Examples of where these factors create error provoking conditions include:

- Look alike boxes for medicines
- Sound alike names for medicines
- Alarms that regularly malfunction on equipment
- Staff being too tired – for example residents who forget patient orders overnight

A range of tools for human factors are available on the WHO web site. All healthcare workers should have an understanding of human factors and their role in error producing conditions.

Safety Management: How Safe Is the Organization?

There are many different forms of harm in healthcare, such as general harm (e.g. health care associated infections), treatment-specific harm (complications, inadequate diagnosis, failure of appropriate treatment; etc) psychological harm. It is important to know the type of harm that is being measured to ensure that the measurement system is appropriate.

There are five essential questions to answer when evaluating safety of a healthcare organization.

1. Has patient care been safe in the past?

Organizations often have data monitoring systems as part of internal management structures. These include mortality statistics; information from case record reviews; incident reporting; and information from routine hospital databases. However just knowing how healthcare has performed in the past is not enough to assess the level of safety in the organization.

2. Are the clinical systems and processes reliable?

Research in the UK found 15% of clinical systems to be unreliable, creating conditions for patient harm. For example 15% of patients in surgical outpatient clinics had clinical information missing when required by the surgeon; in theatres 19% of operations had some problem with equipment. Very few organizations collect data about reliability of clinical systems in terms of quality and safety of patient outcome, but this is crucial for clinicians and managers to improve safety of care.

3. Is care safe today?

Staff absence or a sudden influx of patients can decrease the level of safe care through multiple mechanisms. Such information is often collected during safety walk-rounds; patient handovers; staff and patient briefings; and during other similar procedures.

4. Will care be safe in the future?

Anticipation and preparedness are crucial for patient safety. This class of information about safety is different to that available in most healthcare organizations and needs careful consideration. There are various ways of considering this such as the use of risk registers; human reliability analysis; failure modes and effects analysis; and safety cases. Assessing safety culture is also a way of considering how safe care is now and is expected to evolve in the future.

5. Is the organization responding and improving?

The challenge is to integrate the information available in the organization through an organizational development plan showing that the organization is learning and improving.

Further examples can be found in the main report on measurement and monitoring of safety.
<<http://www.health.org.uk/publications/the-measurement-and-monitoring-of-safety>>

Patient Safety challenges: adapting the WHO safety checklist to specialised surgery in Poland

The National Centre for Quality Assessment (NCQA) has been promoting and supporting hospitals in the implementation of the safe surgery checklist. The safe surgery checklist stays at the core of the 2nd WHO patient safety global challenge and draws on extracted modelling from the airline industry. Following a 2004 article published in the British Medical Journal (BMJ), finding close similarities between the high level of stress and specialization of the operating room and the airplane cockpit, the use of checklists was recommended.

The checklist is neither a regulatory tool, nor a panacea for all safety problems in the operating theatre. It depends on teamwork and is used to ensure all safety steps are followed and drive communication in the operating room in a meaningful way. There are different ways that the checklist is used. In Canada some hospitals have a whiteboard so everyone can see the information. In France it is mandatory to use the checklist and there has been a two year process to expand its use. The checklist has been reduced to 12 core items.

Leadership is essential in implementing the checklist. In 2010 an Initiative Group was set up in Poland to support this process. To ensure compliance with local culture, the Safe Surgery Checklist was translated in local language, adapted and renamed as PeriOperative Control Chart. It was piloted in 465 operations. The occurrence of a tragic case involving wrong kidney removal from a cancer patient in Warsaw triggered nation wide implementation of the checklist recommended by the Ministry of Health. A steering committee was set up and the Polish Society of Surgeons became interested in its use. Currently 88% of anaesthetists and 12% of scrub nurses lead the use of checklists. A recent evaluation study showed 50% of health care staff thought the checklist improved safety in operation theatres, even though it is still seen by some as meaningless bureaucracy. As an additional enforcement measure, the use of the checklist is required in the accreditation process for hospitals. However 40% of hospitals have not yet introduced it, 39% have just started and only 16% have reached successful use. Work is underway to adapt the checklist to specialized surgery in Poland.

Patient Safety Education

The safety level of health care varies widely across health care facilities across the globe and in Europe as well. There are still many countries where unsafe care is seen as something bringing bad publicity at national, local or institutional level, limiting the efforts for remedial action. The required cultural shift, for health care profession, general public and decision making level alike, is a major challenge that needs to be addressed through appropriate information and education. WHO has been working with a broad panel of experts to develop patient safety training tools and include these in the medical school and university education programmes.

The patient safety curriculum guide in multi professional edition that resulted includes 11 topics, including a glossary on patient safety definitions, human factors, learning from errors, managing clinical risk, engaging patients, infection prevention, safe surgery, and medication safety. A

leaders' guide to patient safety and quality in healthcare is being produced. Topics for this training package include safety management systems; financing safety programmes; governance and clinical risk. A similar initiative is being led by the Joint Commission International.

During the discussion, the Czech Republic representatives described their dedicated training, that includes one week course for quality managers; investment in E-learning for induction of all health care professionals; and work on medical and nurse education.

In 2014 the new WHO patient safety challenge will be medication safety. The 'High Fives' programme will continue in association with the collaborating centres, focussing on standardisation with protocols.

Consumer Perception and Participation in Patient Safety

The WHO Patients for Patient Safety programme (PFPS) started with 21 patient champions from 19 countries and over the last ten years has grown to now over 200 patient representatives in many countries worldwide. Work has focused on translating materials for patient education, including patients rights, sharing of patient stories and the need for enhanced communication and health literacy as part of the training of health care staff; health literacy education for patients with non-communicable diseases, articles and TV programmes about patient safety.

The presentation, given by the Polish patient safety champion, included several examples of failure in health care, generated by miscommunications or inappropriate observance of safety requirements. Patient safety champions work nationally and internationally on advocating and raising awareness to governments, national groups, hospital boards, medical students and healthcare workers. They contribute to improving doctor-patient dialogue to achieve concordance with treatment, and the development of patient information briefs. The scope of their work is to help improving health care outcomes through learning from errors, patient empowerment and communication.

Minimal Information Model for Reporting on Safety Incidents

This presentation covered WHO efforts in harmonising reporting and learning processes drawing from health care system failures.

Current developments build on the 2005 draft WHO guidelines for reporting and learning systems, the evidence collected along time in various countries and settings, and on the experience collected by EUnetPAS. Following requests for harmonization of taxonomies of reporting schemes, WHO started work on the development of the minimum information model for patient safety incident reporting. The project aims to develop a checklist for reporting of health care related adverse events, expected to be piloted shortly. More information on this initiative can be found on the WHO dedicated web site http://www.who.int/patientsafety/implementation/information_model/en/index.html

During the discussions that followed, representatives from Czech Republic and Slovakia, expressed interest to participate in the piloting of this tool once developed.

Country reviews

The representatives from Czech Republic, Slovakia, Slovenia and Poland provided an update on their experiences in the field of patient safety and reporting systems, summarized as follows.

Czech Republic

Several normative documents regulate quality and safety of health care: a) Strategy for health care quality and safety of the Ministry of Health, b) Act 372/2011 Coll. on health care services and the conditions of their provision #47 and #98-106 from 01/03/12, c) Decree 102/2012 Coll. on assessment of quality and safety of inpatient care. The health care provider is mandated to implement internal systems/ assessment for quality and safety of health services, external assessment is voluntary, and can be performed by certified companies (defined minimum evaluation standards). Provisions for the national system for reporting adverse events to the national health Information System are part of Act 372/2011 Coll. The implementation of the EU Council Recommendation for Patient Safety and prevention of nosocomial infections is extended to 2014.

The Action plan for quality and safety of health services 2013-2014 focuses on legislative updates enabling assessment of health services, classification and measurement of patient safety and quality of care, education of health care providers and patients, supported by cross border cooperation. A uniform reporting web based methodology became operational 1 January 2013, coordinated by the Institute of Health Information and Statistics. Anticipated next steps include incorporation of the national system for reporting adverse events to the national health information system, with the obligation to report extended to all health care providers. An obligatory on line system for monitoring patient satisfaction will have a pilot launch in January 2014. The national set of 10 health care quality indicators was introduced in April 2013 stemming from OECD collaboration, and the quality review of the Czech system will be completed March 2014.

Poland

The national agency for quality assessment in health care was established by the Ministry of Health in 1994: NCQA Krakow. Its accreditation center becomes operational 1998 based on Joint Commission indicators and Canadian models. It operates since 1998 the hospital accreditation programme, since 2004 the primary health care accreditations programme and since 2013 the addiction centers accreditation programme. Hospital accreditation (project 2008-2014) is supported through European Social Fund Human Capital. To date, there are 127 accredited hospitals. The existing reporting initiatives started following the hospital accreditation programmes.

NCQA became a WHOCC in 2006, and as such leads the PATH project on hospital performance, with a web based platform run by Hungary. Reporting of health care related adverse events is part of the issues monitored and analyzed, on multi-country basis.

There is no national reporting system of adverse events and there is still huge underreporting of health care related and medication.

Slovakia

Several documents provide methodological guidance for quality and safety of care: a) Health Care Surveillance Authority (HCSA) guidelines define patient safety culture and introduce adverse event reporting, b) Patient Safety Strategy in Hospitals (2012-2013) drawing from the adverse event prevalence for inpatient population (performed in 2011 with WHO methodology), includes patient empowerment, c) legislative changes: regulation on quality indicators, adoption of EU directive on patient rights in cross border care and implementation of public health insurance, establishment of reporting system, analysis and learning from adverse events in primary care.

The 2103 health agenda institutionalized patient safety including reporting systems. MoH and HIF assess and provide incentives for patient safety; HCSA collects the reports for adverse events in health care. Reporting is mandatory for adverse events related to medication, devices and blood components (State Institute for Drug Control), vaccinations and health care associated infections (Public Health Authority); data on outpatient/ inpatient activities is collected by the National Health Information Center. Participation in EUnetPAS (2007-2010) and PASQ (2012-2015) is part of the regional network exercise on shared good and transferable experiences and safe clinical practices.

Slovenia

The national system for adverse events reporting and learning was established by MoH in 2001 (based on sentinel events alert of the Joint Commission), with no specific IT support. Following a dramatic incident in 2008, increased attention started to be given to safety management.

A national strategy for quality and safety in health care 2010-2015 was developed with particular focus on education to health care safety. The new Health Services Act includes reporting of all safety issues (and IT support) and has been recently passed through Parliament. Within this framework, MoH has been particularly active in accreditation (11 of 29 hospitals accredited) and monitoring quality performance indicators (71 indicators), with financial incentives set by HIF. MoH report on quality and safety in Slovenian hospitals sets specific annual goals. It is complemented by the annual report of patient ombudsperson. Successful experiences such as the University Clinical Centre Ljubljana (2200 beds, reporting since 2000, web based since 2008, operational patient council) are expected to be expanded at national scale.

The EU funded patient safety draft project on minimal requirements for reporting systems was presented through skype from Geneva. The project aims to develop a checklist for reporting of health care related adverse events, promoting harmonization in the reporting schemes. Two of participating countries: Czech Republic and Slovakia, expressed interest to participate in the piloting of this tool once developed.

Round table discussions

Teamwork and communication in patient safety: bridging safety information

The discussion was preceded by a presentation on 'never events'. The case study concerned a cancer patient with wrong side surgery, and the full report analysing 9 'never events' is available at: <http://www.chfg.org/wp-content/uploads/2012/03/Never-Events-final2-1.pdf>.

Never events are failures related the health care generating serious patient harm, and that should be totally preventable. The use of standardised protocols and checklists, appropriate notes and unified coding and abbreviations, as well as recognizing the environmental factors (i.e. stressor agents, cultural barriers) are part of the prevention mechanisms. A human factor approach should allow realistic evaluation of the working environment and prospectively assessing risk, with particular relevance when introducing changes in an established routine or workflow.

The system view suggested by the recent review performed by the Clinical Human Factors group identifies as main entry points for monitoring: equipment availability and complexity, sharing information at appropriate points in the process of care, clear distribution of tasks in following standardized work protocols, organization and communication between team members and different categories of staff complementary to the team, plus situation awareness (i.e. coping with stress and fatigue) and adequate information exchange and follow up.

Human and organizational factors are part of the elements to be considered in the process of risk assessment and evaluation, and in developing strategies for improving team work and communication for patient safety.

Planning Future Safety Programmes and the role of networks in improving quality and safety of health services and consumer satisfaction

Extracting from the country experiences, patient safety interventions presented and supportive evidence, and to reignite high level resonance of patient safety on health agendas, the need for a new language for safety has been discussed. Therefore, the application of safety management could be seen as work on human and organizational factors, drawing from continuous monitoring and learning mechanisms and supported by communities of practice and information exchange. Patients' role in improving safety would require self management and professional interaction, drawing from education to health, and support from communities of learning as platforms for shared experience and multi stakeholder networks.

In the planning of future safety programmes, three main directions bridging the above could be considered: safety of systems, safety of services and safety of users, supported by shared information (communities of practice and communities of learning), and enhanced communication (teams and networks), at national and/or local level. The priority interventions to make the system safer, the service safer, and get the user involved for safety identified by participants are listed below.

- **Education:** this is a top priority in building safety culture for healthcare. Training in patient safety and human factors should get increasing recognition in the medical curriculum and continuing medical education activities, for steering change. Health education for the general population should build in parallel individual and patient health literacy (the capacity to understand and interact with health care professionals in the process of care), as active participant in steering health service safety.
- **Leadership:** The Ministries of Health (MoH) as regulators and the Health Insurance Funds (HIF) as payers play a strong role in the implementation of quality and safety interventions (e.g. standards of care), therefore the need to create a sense of urgency by providing data and initiate action. National quality and safety legislation, strategy and action plans have been developed in some countries, with dedicated responsibilities per stakeholder. These have included patient safety campaigns and education of health care professionals, managers and leaders, with media support as part of public information (e.g. TV series in Poland on patient safety).

- **Technologies:** Information technologies are increasingly important for collecting reports centrally, and monitoring use of standardized procedures and protocols. Strong information management and latest clinical technology components are however not sufficient to strengthen quality and safety of care. These need to be supported by organizational change and culture change, therefore the need to be considered in the framework design of scalable interventions.
- **Safety reporting culture:** There is still a fear in hospitals about damage to their reputation if they speak up about patient safety that must be overcome – engaging the media in understanding patient safety and sharing lessons learned is needed. It was considered that establishing a national reporting system should be funded by MoH and HIF at service level. Educational programmes for patients and patients' organisations are among priorities in enabling patients to understand and report safety challenges.
- **Partnership and networks:** Non Governmental Organizations and Scientific Medical Societies are involved in patient safety work in different countries and lessons could be shared between countries and stakeholders. Dedicated and related networks provide the opportunity to share knowledge, good practices, national and international experiences.

Conclusions and recommendations

During the workshop, several areas for action were seen as pre requisites for sustainable interventions, collaboration and information exchange for patient safety.

Education to Patient safety: Appropriate provision of information and capacity building in patient safety and quality of care for health care workers and patients could support anticipation and preparedness for patient safety. Sensitizing the leadership level to safety management is part of this process. Investment in e-learning communities can facilitate induction for all health care workers, and include patient and community education.

Patient safety improvement: Reporting and learning mechanisms should be incorporated at all levels of health care provision, with defined reporting responsibilities. Open to health care professionals and patients, accountable but non-punitive reporting of health care related failure should become a procedure regulated at national level. Compiled analysis of results should be made publicly available annually and support corrective actions in health care. The role of payers in incentivising patient safety improvement should be given further consideration.

Networks for learning: Shared experiences and best practices about managing adverse events in organizations; integrating information about safety, staff and patient education, successful patient safety interventions is the role of networks. Multi country events like the present workshop foster collaboration and enable creating and expanding such networks and contribute to the development of communities of learning. Information gained during the event is expected to be further disseminated by participants at national and international, and further enhance collaboration with already existing EU, OECD and WHO safety initiatives.

Within the context of Health 2020, a value and evidence based health policy framework for health and wellbeing among the people of the WHO European region, patient safety plays an important role in the development and implementation of people centred care, supported by information exchange, wide partnership and multi stakeholder cooperation.

Annex 1: Programme of work

Monday 23 September

08:30 – 09:00	<i>Registration</i>	
09:00 – 09:30	Official opening <i>National health authorities, WHOCC, WHO CO</i>	Dr A. Lesniewska Dr J. Hennig Dr P. Miskiewicz
09:30 – 10:00	Patient safety and patient centred care in integrated health systems: prevention, cure and care	Dr V. Hafner <i>presentation+ discussion</i>
10:00 – 10:30	<i>Coffee/ tea break</i>	
10:30 – 12:30	Session 1: Advancing patient safety interventions <i>reporting on local progress & BCA</i> <ul style="list-style-type: none"> • Patient safety interventions updates in CZH • Patient safety interventions updates in POL • Patient safety interventions updates in SVK • Patient safety interventions updates in SVN 	Country representatives Dr Z. Hrib Dr B. Kutryba Dr P. Bandura Dr M. Poldrugovac
12:30 – 13:30	<i>Lunch</i>	
13:30 – 14:30	Human factors engineering	Dr A. Leotsakos <i>presentation+ discussion</i>
14:30 – 15:30	Safety management/ clinical risk management How safe is the organization:	Dr S. Burnett <i>presentation+ discussion</i>
15:30 – 16:00	<i>Coffee/ tea break</i>	
16:00 – 16:45	Consumer perception and participation in patient safety	Dr Y. Bilinska <i>presentation + discussion</i>
16:45 – 17:45	Team work and communication in patient safety - bridging safety information: never events	Plenary discussion
17:45 – 18:00	Conclusions of day 1	Dr B. Kutryba

Tuesday 24 September

09:00 – 09:45	Patient safety challenges: adapting safety checklist to specialized surgery	Dr B. Kutryba <i>presentation+ discussion</i>
09:45 – 10:30	Patient safety education and safety management	Dr A. Leotsakos <i>presentation+ discussion</i>
10:30 - 11:00	<i>Coffee/ tea break</i>	
11:00 – 12:30	Session 2: Advantages/ benefits of reporting & learning systems: presentations from participating countries	Country representatives Dr P. Danko Dr H. Kutaj-Wasikowska Dr E. Nagy Dr M. Poldrugovac
12:30 - 13:30	<i>Lunch</i>	
13:30 – 14:15	Minimal information model for reporting on patient safety incidents	Dr I. Larizgoitia <i>(via skype)</i>
14:15 – 15:00	Planning future safety programmes (I)	Dr S. Burnett <i>presentation+ discussion</i>
15:00 - 15:30	<i>Coffee/ tea break</i>	
15:30 – 16:30	Planning future safety programmes (II)	Plenary discussion
16:30 – 17:00	The role of networks in improving quality and safety of health services and consumer satisfaction	Plenary discussion
17:00 – 17:30	Conclusions and closure of the event	

ANNEX 2: LIST OF PARTICIPANTS

Czech Republic

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ANNEX 3: VERBATIM NOTES FROM THE WORKING MEETING ON TECHNICAL REVISION OF ADAPTED SAFE SURGERY CHECKLISTS FOR POLAND, 25 SEPTEMBER 2013, KRAKOW

The working meeting was coordinated by WHO CC and took place as back to back meeting to the WHO Multicounty Patient Safety Worksop (22-23 September 2013) in Krakow.

The goal of the 'Safe Surgery Saves Lives' Challenge is to improve the safety of surgical care around the world by ensuring adherence to proven standards of care in all countries. WHO Surgical Safety Checklist has improved compliance with standards and decreased complications from surgery in hospitals. Within this context, patient safety and patient participation stand as a firm priority for strengthening health care systems and a pre requisite for its open market sustainability. The change in disease patterns worldwide is increasing the need for surgical services considerably. Epidemics and infections are giving way as leading causes of death to ischemic heart diseases, cancers, and trauma - which need surgical interventions. Ensuring better access to surgical care and its safe delivery is crucial for its effectiveness. The available evidence suggests that as many as half of the complications and deaths arising from surgery could be avoided if certain basic standards of care were followed.

The meeting was organized within the BCA 2012-13 WHO/EURO as a continuation of work related to adaptation of surgical safety checklists in five medical specialties: cardio-surgery; orthopaedics, ophthalmology; children surgery and neurosurgery. It was attended by Dr. Agnes Leotsakos from the WHO patient safety programme in Geneva, and local experts involved in the safe surgery checklist adaptation and use.

The aim was to present the drafts of checklists and have a peer review over their content and use in the operating room, according to specialty. This review looked into technical relevance, clearness, and compliance with checklist requirements.

The meeting started with a WHO presentation on applying human factors to safe surgery and patient care. It was followed by presentation and discussion of the locally adapted tools.

The discussion concerning the responsibility levels in applying the checklists was initiated by the presentation of the neurosurgery checklist that places the responsibility on the nurse only. Discussions look into who should be the coordinator and whereas the coordinator should be a single individual, irrespective of profession, or if there could be different coordinators for the sign-in, time-out and sign-out phases of the checklist.

The presentations from the remaining specialties triggered the similar remarks that can be synthesized as follows: should the checklist be clear and simple or should it be more extensive; can pulse-oxymetry be abandoned; should the blood supply be included in all checklists; should ophthalmologists perhaps simplify their checklist and develop versions for the less complex procedures in local anaesthesia and for the ones in general anaesthesia; should introductions of the checklist be made only in case there is a new member on the team or the roles played in surgical procedures should be introduced on each occasion?

It was agreed that the checklists will undergo further revision, based on the comments received from the WHO expert and peers and that the revised versions should be piloted in at least two medical centres until the end of November 2013. The conclusion will be presented in view of the official recommendation for national use of checklists during a final conference to be held on 13 December, 2013 at the Ministry of Health in Warsaw.