Federal Ministry
of Health

Abstracts and Speakers

2nd Global Ministerial Summit on Patient Safety 2017

Contents

Introduction

Federal Minister of Health Hermann Gröhe will host the Second Global Ministerial Summit on Patient Safety in Bonn on 29/30 March 2017. There is a national consensus among the policy-makers, the medical profession, hospitals and health insurance funds as well as patient groups and industry that safety must be a key theme in taking our health care system further. On the international level, too, awareness of patient safety is rising steadily.

This is why Federal Minister of Health Hermann Gröhe has teamed up with his British counterpart, Jeremy Hunt, to launch an exchange among their opposite numbers around the globe. The immediate result of this initiative was the Patient Safety Global Action Summit in London in the spring of 2016. Now, Federal Minister Hermann Gröhe has invited ministers from more than 50 states and high-ranking representatives of international organisations including the World Bank, the OECD and the Council of Europe, to attend the second Ministerial Summit.

On the first day, German and international experts, joined by representatives of WHO and OECD, will address the current challenges facing patient safety at the former seat of the German Bundestag in Bonn. The workshops will cover a spectrum of topics including the economy and efficiency of patient safety as well as global exchange.

More concrete issues such as mobile health or how to prevent and control infections are also on the agenda. The following day, the ministers and secretaries and their delegations will discuss health policy consequences

Bundesgesundheitsminister Hermann Gröhe ist Gastgeber des zweiten internationalen Ministergipfel zur Patientensicherheit am 29. und 30. März 2017 in Bonn. In der Politik, in der Ärzteschaft, bei den Krankenhäusern ebenso wie bei Krankenkassen, Patientenvertretungen und der Industrie besteht Einigkeit, dass die Patientensicherheit ein Leitgedanke bei der Weiterentwicklung des Gesundheitswesens sein soll. Auch international wächst die Aufmerksamkeit für Patientensicherheit stetig. Aus diesem Grund haben Bundesgesundheitsminister Gröhe und sein britischer Amtskollege Jeremy Hunt eine Initiative gestartet, um weltweit mit ihren Amtskollegen in Austausch zu treten. Im Frühjahr 2016 fand in London ein erster Patient Safety Global Action Summit statt.

Bundesgesundheitsminister Hermann Gröhe hat nun zum zweiten Treffen von Ministern aus mehr als 50 Staaten sowie Vertretern internationaler Organisationen wie der Weltbank, der OECD und des Europarates eingeladen. Im ehemaligen Sitz des Bundestages in Bonn werden am ersten Tag deutsche und internationale Expertinnen und Experten unter Beteiligung von WHO und OECD die aktuellen Herausforderungen für Patientensicherheit diskutieren. In den Workshops geht es um die Themen Ökonomie und Effizienz der Patientensicherheit sowie um den globalen Austausch. Auch konkrete Fragestellungen wie zum Beispiel Infektionsvermeidung oder mobile Health sollen erörtert werden. Am zweiten Tag beraten die Minister und Ministerinnen mit ihren Delegationen über gesundheitspolitische Konsequenzen.

Plenary Sessions

Karin Knufmann-Happe

Ministerialdirektorin (Director-General), Head of Directorate-General 3 for ' Health Protection, Disease Control and Biomedicine at the German Federal Ministry of Health

Welcome Address

Moderation Expert Meeting

Speaker Information:
Following her studies of law and practical legal training, Karin Knufmann-Happe (* 1961), who is married, has two children, and is a fully qualified lawyer, joined the Federal Ministry of Labour and Social Affairs in 1989.

From 1992 to 1995, Ms Knufmann-Happe was seconded to the European Commission in Brussels where she worked as a national expert in the 'Pharmaceuticals' Unit of Directorate-General III (Industry).

Since February 1995, Ms Knufmann-Happe has held various functions at the Federal Ministry of Health and the Federal Ministry of Health and Social Security.

In 2005, Ms. Knufmann-Happe was appointed Director General of Directorate-General 5 for 'Matters relating to Disabled Persons, Social Assistance' at the Federal Ministry of Health and Social Security. In 2006, she took over as Director General of Directorate-General 3 for 'Health Protection, Disease Control and Biomedicine" at the German Federal Ministry of Health.

Ruth Hecker

Essen University Hospital, Head of executive department of Quality management and Risk management

Opening Plenary

Speaker Information:

Dr. Ruth Hecker has several years of experiences and expertise in the health care system both from a practical and a theoretical point of view. She began her career as a nurse in intensive care, and further worked as a physician in anaesthesiology.. Furthermore she holds scientific qualifications in health sciences and is specialized in quality management and clinical risk assessment. She developed and established quality management systems in several hospitals and social advisory services and retirement homes. Currently she is the Head of Quality Management and Clinical Risk Management at the Essen University Hospital. Since October 2016 she is the deputy chair of the German Coalition for Patient Safety, a non-profit association of organisations and individuals interested and involved in promotion of patient safety.

Sir Liam Donaldson

World Health Organization, Envoy for Patient Safety, Switzerland

Opening Plenary

Speaker Information:

Professor Sir Liam Donaldson is recognised as an international champion of public health and patient safety. He was the foundation chair of the World Health Organisation's World Alliance for Patient Safety, launched in 2004. He is a past vice-chairman of the World Health Organisation Executive Board. He is now the World Health Organisation's Envoy for Patient Safety, Chairman of the Independent Monitoring for the Global Polio Eradication Programme, as well as Chairman of the Transition Monitoring Board of this Programme. In the UK, he is Professor of Public Health at the London School of Hygiene and Tropical Medicine, Honorary Distinguished Professor at Cardiff University, Associate Fellow in the Centre on Global Health Security at Chatham House, and Chancellor of Newcastle University.

Prior to this appointment Sir Liam was the 15th Chief Medical Officer for England, and the United Kingdom's Chief Medical Adviser, from 1998-2010. During his time in this historic post (established in 1855) he held critical responsibilities across the whole field of public health and health care. As the United Kingdom's chief adviser on health issues, he advised the Secretary of State for Health, the Prime Minister and other government ministers. He has produced landmark reports which have set health policy and legislation in fields such as stem cell research, clinical governance, quality and safety of health care, infectious disease control, patient empowerment, poor clinical performance, smoke free public places, medical regulation, and organ and tissue retention. He has published over 200 papers in peer-reviewed journals and is author of a standard textbook of public health that has been in continuous print for 30 years and co-author of the history of the Chief Medical Officers of England. He has made many media appearances as part of his professional roles.

Sir Liam initially trained as a surgeon in Birmingham and went on to hold teaching and research posts at the University of Leicester. In 1986, he was appointed Regional Medical Officer and Regional Director of Public Health for the Northern Regional Health Authority.

Sir Liam has received many public honours: 12 honorary doctorates from British universities, eight fellowships from medical royal colleges and faculties, and the Gold Medal of the Royal College of Surgeons of Edinburgh. He was the Queen's Honorary Physician between 1996 and 1999. He was knighted in the 2002 New Year's Honours List.

Guenther Jonitz

Berlin Chamber of Physicians, President, Germany

Opening Ministerial Meeting

Speaker Information:

Dr. med. Guenther Jonitz is born in Munich, Germany, on 19. June 1958. License to practice medicine in 1984, specialist for surgery in 1994, qualification as doctor of medicine in 1996. Since 1999 President of the Berlin Chamber of Physicians and a member of the board of the German Medical Association, where he is responsible for quality assurance of medical activity. He is Chair of the quality assurance bodies of the German Medical Association (BÄK) and representatives of the German Medical Association Board of Trustees of the Institute for Quality and Efficiency in Health Care (IQWiG) and of the Institute for Quality and Transparency in Health Care (IQTIG). He is founding member and formerly Chair of the German Coalition for Patient Safety (APS) as well as founding member of the German Network for Evidence Based Medicine (DNEbM). He is working as expert and advisor of the German Federal Ministry of Health (BMG) on questions relating to patient safety in international organizations (e.g. EU Commission). He is also the leader of the nation-wide German working group “Patient Safety” which started its work in October 2014. This working group is part of the national programme “Gesundheitsziele.de”.

In the year 2016 he was awarded with the Federal Cross of Merit (Bundesverdienstkreuz) for his achievements in the area of patient safety.

Victor J Dzau

National Academy of Medicine, President, USA

Keynote Ministerial Meeting

Speaker Information:

Victor J Dzau, MD, is President of the US National Academy of Medicine. Born in Shanghai and reared in Hong Kong, he is an internationally acclaimed leader and scientist whose work has improved health care in the United States and globally. Under his direction, the National Academy of Medicine/Institute of Medicine advances research and improves health by providing objective, evidence-based guidance on critical issues. His foresight in translation of research into innovative medicines, and creative solutions for human health issues is a great asset to the public at large. His own research laid the foundation for development of angiotensin-converting-enzyme (ACE) inhibitors, used globally to treat high blood pressure and congestive heart failure. He pioneered gene therapy for vascular disease and was the first to introduce DNA decoy molecules to block transcription as gene therapy in humans. He is a member of the board of directors of the Singapore Health Services, a former member of the Advisory Committees to the Director of U.S. National Institutes of Health and the International Review Board of the Canadian Institute for Health Research. He chaired NIH's Cardiovascular Disease Advisory Committee and is past chair of the Association of Academic Health Centers. In 2011, Dzau led a partnership among Duke Medicine, the World Economic Forum, and McKinsey & Co. to establish the International Partnership for Innovation in Healthcare.

Prior to becoming President of the National Academy of Medicine, Dr. Dzau served as Chancellor for Health Affairs and President & CEO of Duke University Health System. Earlier academic appointments include serving as the Hersey Professor and Chair of Medicine at Harvard Medical School and Brigham and Women's Hospital, and Arthur Bloomfield Professor and Chair of Medicine at Stanford University. He has received numerous awards including the Max Delbruck Medal from Humboldt University, Charité and Max Planck Institute, the Gustav Nylin Medal from the Swedish Royal College of Medicine, the Polzer Prize from the European Academy of Sciences & Arts, the Ellis Island Medal of Honor, and the Distinguished Scientist Award of the American Heart Association. Dzau received his undergraduate and medical degrees from McGill University.

Gary Kaplan

Virginia Mason Health System, Chairman and CEO, USA

Video Message Ministerial Meeting

Speaker Information:

Gary S. Kaplan, MD, FACP, FACMPE, FACPE, has served as chairman and CEO of Virginia Mason Health System in Seattle since 2000. He is also a practicing, board-certified internal medicine physician at Virginia Mason.

He is chair of the Institute for Healthcare Improvement Board of Directors and the chairman of the Lucian Leape Institute. He was elected to membership in the Institute of Medicine in 2013.

Dr. Kaplan received a degree in medicine from the University Michigan Medical School. He is a Fellow of the American College of Physicians (FACP), the American College of Medical Practice Executives (FACMPE) and the American College of Physician Executives (FACPE).

With Dr. Kaplan's leadership, in 2002 Virginia Mason became the first health system in the United States to adapt the principles of the Toyota Production System as its management methodology for identifying and eliminating waste, improving quality and safety, and controlling cost. In 2010, Virginia Mason was named a Top Hospital of the Decade by The Leapfrog Group, a national non-profit organization representing employers and other large purchasers of health care that are driving improvements in quality, safety and transparency.

Egbert M. Schillings

World Innovation Summit for Health (WISH) at Qatar Foundation, CEO, Qatar

Moderation Ministerial Meeting

Speaker Information:

Egbert Schillings was appointed Chief Executive Officer of the World Innovation Summit for Health (WISH) at Qatar Foundation in 2014. Mr Schillings is a business leader with 25 years' experience in the global healthcare industry, across payers, provider systems, best practice research, and consulting. As CEO, Egbert Schillings has led the evolution of WISH into a research based and action focused global community of like-minded leaders, dedicated to improving healthcare through accelerating the innovation cycle for the benefit of populations everywhere. WISH is dedicated to capturing and disseminating the best evidence-based ideas and practices, creating an evidence base for healthcare policy. WISH is an initiative of Qatar Foundation for Education, Science and Community Development (QF) and is under the patronage of Her Highness Sheikha Moza bint Nasser, its Chairperson.

Patient Safety has been a core area of focus for the program since its inception because of Mr Schillings commitment to the issue. In 2015 WISH published a landmark report on taking a systems-approach to patient safety; the research was headed by Peter Pronovost at Johns Hopkins University and specifically looked to the defence industry for lesson in safety applicable to health care. For the past two years WISH, together with Imperial College London, has convened the Leading Health Systems Network (LHSN), a group of health systems in 13 countries committed to reducing harm through joint inquiry and mutual support. We recently published our findings on comparing harm reporting at a systems level: "An International Perspective on Patient Safety: What can we learn about measuring safe care?" across systems in India, Australia, New Zealand, Spain, England, Scotland, and Singapore.

Previously, Egbert Schillings was SVP of Client Service for McKinsey's Health Systems Institute in London. He has deep expertise in performance improvement, leadership development, and patient safety in healthcare systems, having worked with systems in over 20 countries. Prior to joining McKinsey, Egbert Schillings served as Managing Director at Kaiser Permanente in Oakland, California, the largest fully integrated health care system in the United States. He was a Senior Director at The Advisory Board Company, a provider of best practice research, business intelligence and consulting services to the healthcare sector. In Washington, DC, he worked on public health and insurance industry legislation for The American Lung Association and for the Health Insurance Association of America (HIAA). He also served as a legislative aide to the honourable Lee H. Hamilton (D-Indiana) in the U.S. House of Representatives. Egbert Schillings received his MA at Freie Universität Berlin and was a Fulbright Scholar in Political Science at George Washington University in Washington D.C.

Workshop 1: Economy and Efficiency of Patient Safety

On the one hand, the aim of the workshop shall be to analyze the economic effects and the efficiency of procedures for the improvement of patient safety at international level. In preparation of this topic, OECD will conduct an international study on economic consequences of patient safety, which is going to regard longer-term and indirect consequences of improved patient safety. On the other hand, the efficiency of patient safety measures will be examined with special attention being paid to safety culture and the influence that leadership style and patients' involvement have in this respect.

Ziel dieses Workshops soll zum einen sein, die ökonomischen Auswirkungen und die Effizienz von Maßnahmen zur Steigerung der Patientensicherheit auf internationaler Ebene zu analysieren. Vorbereitend wird von der OECD eine internationale Studie zu den ökonomischen Konsequenzen erstellt, in der auch längerfristige und indirekte Folgen verbesserter Patientensicherheitsmaßnahmen betrachtet werden sollen. Zum zweiten soll die Effektivität von Patientensicherheitsmaßnahmen beleuchtet werden, wobei besondere Aufmerksamkeit der Sicherheitskultur und deren Beeinflussung durch Führungsverhalten und Patientenbeteiligung zuteil wird.

Chair: Dr. Ingo Härtel

Senior Science Advisor, German Federal Ministry of Health, Germany

Chair Information:

Dr. Ingo Härtel, holds a doctorate in medicine from the Charité, Berlin and an MA in bioethics from the Kennedy Institute of Ethics, Georgetown University, Washington, DC. His current position is that of Senior Science Advisor in the Health Law & Patient Rights Unit at the German Federal Ministry of Health, where his responsibilities lie in the fields of patient safety and bioethics. Prior to his current post, he worked for the office of the Study Commission "Law and Ethics in Modern Medicine" at the German Bundestag. Currently he is representing Germany at the Bioethics Committee of the Council of Europe and at the Intergovernmental Bioethics Committee of the UNESCO. He has served as the Secretary General of the Inter-Ministerial Working Group on Regulatory Affairs in Biomedicine and Bioethics and as delegate to the OECD's Working Party on Biotechnology.

The Economics of Patient Safety: Strengthening a Value-based Approach to Reducing Patient Harm at National Level

Niek Klazinga, MD PhD, Coordinator Health Care Quality Indicator program, OECD, Paris, France

Abstract:

This presentation will summarize the finding of an OECD report on the Economics of Patient Safety. The report comprises two sections:

1. The cost of failure. Estimating the costs of lapses in patient safety. Costs are quantified in terms of disease burden (morbidity and mortality), and financial and resource impact on the healthcare system. An exploration is made of the (dis)balance between investments to prevent harm (prevention costs) and failure costs. This part of the report is informed by a review of the literature.
2. Reducing harm effectively and efficiently. Exploring a value-based approach to investing in patient safety in a resource-constrained context. The relative costs and impact of various interventions (and combinations thereof) targeting patient harm across healthcare systems are estimated using a snapshot survey of international patient safety experts and policy makers. A total of 10 academics and 15 countries participated in the study. The relative impact and cost of 40 patient safety strategies were explored on national level (i.e. standards/accreditation, public reporting, professional education and training, no-fault medical negligence legislation), organisational (institutional) level (i.e. clinical governance, safety culture, person- and patient- engagement initiatives) and clinical level (i.e. medication management, VTE prevention, prevention pressure ulcers and infections).

Conclusions and key elements of the report are:

- Patient safety is a critical policy issue.
- The cost to patients, healthcare systems and societies is considerable
- Most of the burden is associated with a few common adverse events.
- Greater investment in prevention is justified.
- Solid foundations for patient safety need to be in place.
- Active engagement of providers and patients is critical.
- Innovation at the clinical level is enhanced through national leadership.
- Practical approaches exist to identify national priorities for action.

Keywords: Patient safety, economics, prevention costs, failure costs, value-based safety strategies

Speaker Information:

Niek Klazinga, MD PhD is presently the coordinator of the Health Care Quality Indicator project at the OECD in Paris. He combines this work with a professorship in Social Medicine at the Academic Medical Centre at the University of Amsterdam. Niek has been involved over the past 30 years in numerous health services research projects and policy debates on quality of care and patient safety. Present commitments include a visiting professorship at the Corvinus University in Budapest and the University of Toronto, advisor to WHO, member of the board of trustees of the Isala Clinics (Zwolle; one of the largest teaching hospitals in The Netherlands) and Arkin (Amsterdam; one of the largest mental health care institutes in The Netherlands). In the latter institutes he is the chair of the quality and safety committee. He has to date (co)authored over 220 papers in peer-reviewed journals and supervised 36 PhD students.

Patient Safety and Implementation Science: New Developments

Jeffrey Braithwaite, Prof., Australian Institute of Health Innovation, Macquarie University, Australia

Abstract:

The OECD report, The Economics of Patient Safety: Towards a Value-Based Approach of Reducing Patient Harm at National Level [1] argues for the importance of tackling harm to patients in a range of key areas; infections, venous thromboembolism, pressure ulcers, medication error and wrong or delayed diagnosis. The basis for this is that these are major contributors to the burden of harm and cost to health care systems.

Low-, middle- and high-income countries have differing infrastructure, resources, and capacities to mitigate harm. In this talk we discuss the implications of the OECD report and advance implementation strategies that can be tailored for different kinds of health systems. We also need to recognise the importance of understanding when things go right (Safety-I) as well as when things go wrong (Safety-II) as a way of developing implementation strategies relevant to the circumstances in different countries [2].

References:

1. Slawomirski, L., Auraaen, A. and Klazinga, N. The Economics of Patient Safety: Towards a Value-Based Approach of Reducing Patient Harm at National Level. 2017, Paris: OECD.

2. Hollnagel, E., Braithwaite, J. and Wears, R. Resilient Health Care. 2013, Farnham, Surrey: Ashgate Publishing Ltd.

Keywords: patient safety, OECD, Safety-I, Safety-II, implementation science

Speaker Information:

Professor Jeffrey Braithwaite, BA, MIR (Hons), MBA, DipLR, PhD, FAIM, FCHSM, FFPHRCP (UK), FAcSS (UK), Hon FRACMA, is Foundation Director, Australian Institute of Health Innovation, Director, Centre for Healthcare Resilience and Implementation Science, and Professor of Health Systems Research, Faculty of Medicine and Health Sciences, Macquarie University, Australia. His research examines health care as a complex adaptive system, and applying complexity science to health care problems. He has attracted funding of more than AUD$102 million. He has received 31 different national and international awards for his teaching and research, and he is a board member of the International Society for Quality in Health Care (ISQua).

Culture and the Economics of Patient Safety

Luke Slawomirski, Health Economist, OECD, Paris, France

Abstract:

The debate about patient safety has shifted from isolated interventions aimed at care delivery to a systems approach that - recognizing the dynamic complexity of health care - demands a broader socio-technical transformation to enable consistently high safety across entire healthcare systems. This shift has been accompanied by an appreciation of organizational culture as a requirement in this transformation. A recent OECD survey of experts to elicit a value-based approach to safety at national level identified a 'culture conducive to safety' as fundamental to success. However, the notion of culture can be somewhat intractable and difficult to distil into concrete initiatives or interventions for policy makers, providers and clinical teams. This presentation will describe the key attributes of a safety culture, and how it can potentially be established and embedded across entire health systems - as opposed to isolated pockets of excellence. It will draw on the available literature, real-world examples, and the results of the expert survey on the economics of patient safety.

Keywords: patient safety, culture, economics, value

Speaker Information:

Luke Slawomirski is a health economist and former clinician now working with the OECD Health Division in Paris, France. Previously he was Program Manager at the Australian Commission on Safety and Quality in Health Care where his activities included a national framework for incident disclosure, pricing for quality, and the Australian Atlas of Healthcare Variation. Luke is a Visiting Fellow at the University of Technology Sydney. His main interests are healthcare quality improvement and the political economy of health.

Keeping Patients Safe: The Role of Competent Communication

Annegret F. Hannawa, Prof. Dr. Associate Professor and Director, Center for the Advancement of Healthcare Quality and Patient Safety (CAHQS), Università della Svizzera italiana, Switzerland

Abstract:

We cannot not communicate–all behaviour, even passiveness or silence, carries meaning and potentially communicates something to others, whether we intend it or not. Just because we communicate most of the time, however, does not mean that we communicate competently. Miscommunication is the rule rather than the norm in our social encounters, and while communication is often considered a "soft skill" in healthcare, it directly affects our health and well-being. If communication goes well, we are healthier. If communication goes poorly, it severely compromises our health and the health of those around us. The healthcare setting poses significant barriers to "health-promoting" communication: In-tense time pressures, professional hierarchies, emotional message contents, many involved care participants, noisy environments, and a high-stakes context of patients' life and death create setting in which miscommunication and interpersonal conflicts is frequent and inevitable. However, itis exactly in this setting where care participants (both patients and providers) experience a particular need for both appropriate and effective communication in order to optimize care outcomes. Prevalent studies have shown that if their communication fails, patient safety is put at significant risk. Professor Hannawa will present an innovative "SACCIA" framework that she developed based on her empirical research in communication science. The framework identifies core communication errors that commonly compromise patient safety in everyday healthcare encounters. It conveys that care participants (both providers and patients) can prevent many patient safety events by encoding, decoding, and making sense of messages in ways that are sufficient(S), accurate(A), clear(C), contextualized(C), and interpersonally adaptive(IA). These "SACCIA" skills are evidence-based and necessary to enhance patient safety. Therefore, they need to be taught to practicing clinicians (i.e., physicians and nurses) and future clinicians at all levels (i.e., basic and continuing education) as a core competency, so they learn how to use these skills effectively in everyday care encounters. Such interventions promise to effectively reduce the count, severity, and associated costs of preventable patient safety events in hospitals, primary care, and home care settings.

Keywords: Communication competence, Communication skills, Communication errors, Safe communication, Core competencies

Speaker Information:

Prof. Dr. Annegret Hannawa founded and directs the Center for the Advancement of Healthcare Quality and Patient Safety (CAHQS) at the Università della Svizzera italiana in Switzerland. She also serves as Associate Faculty at the Bloomberg School of Public Health at Johns Hopkins University (USA), and as Honorary Research Associate at Cardiff University's School of Medicine (UK). In 2013, she founded the ISCOME Global Institute for the Advancement of Communication in Healthcare to activate global interdisciplinary research collaborations that harness communication science to improve the safety and quality of care. Her research focuses on evidence-based communication skills interventions that effectively reduce the cost (in both human and monetary terms) and the prevalence of preventable patient safety events. Her scientific achievements have been recognized with numerous inter-national awards.

Enhancing Caregiver Resilience: The Role of Staff Support

Albert W. Wu, Prof., Johns Hopkins Bloomberg School of Public Health, Professor, USA

Abstract:

Growing attention is being paid to improving systems to make health care safer, and to being open with patients harmed during the provision of medical care. In contrast, there has been little attention to helping health care workers cope with adverse events. “Second victims” are nurses, physicians and other providers who, in addition to patients and families, are also traumatized by adverse events. Many experience grief, fear, intrusive thoughts, somatic symptoms and self-doubt. In the short term, some have difficulty coping, and their performance may be impaired, posing additional patient safety risk. A few develop longer-term problems similar to post traumatic stress disorder, contributing to the increasingly prevalent problem of burnout. Recently, programs have been developed to help care for health care workers after adverse patient events. One such program is the RISE (Resilience in Stressful Events) peer support program at Johns Hopkins, which provides timely psychological first aid to staff members who encounter stressful patient-related events. This program has been demonstrated to save hospital costs. Stress and burnout are universal problems that threaten both the well-being of health care workers and the safety of patients. Hospitals should be encouraged by these findings to implement institution-wide support programs for medical staff, based on the high demand for this type of service and the potential for cost savings.

Keywords: burnout, second victim, resilience, support, cost-benefit

Speaker Information:

Albert Wu is a practicing internist and Professor at the Johns Hopkins University. He is director of the Center for Health Services & Outcomes Research, the PhD in Health Services Research, and the online Masters of Applied Science in Patient Safety & Healthcare Quality. He has studied patient safety since 1988, and was Senior Adviser for Patient Safety to WHO in Geneva. He coined the term “Second Victim” and co-directs the RISE staff support program at Johns Hopkins Hospital. He is Associate Editor for the Journal of Patient Safety, and leads on measures of patient safety and care quality for the Armstrong Institute.

From Local to National: Compensation Management and the Italian Patient Safety Law

Tommaso Bellandi, PhD Eur. Erg., Deputy Director - Centre for Clinical Risk Management and Patient Safety, Florence, Italy

Abstract:

Tuscany Region started its program for patient safety in 2004, by setting up a system for clinical risk management with the aim of improving safety and efficiency with a systems approach based on ergonomics and human factors. The public health service has got 36 hospitals and 32 primary care districts, accounting for a population of 3.6 millions. We designed a dedicated information system to integrate data from the volountary and mandatory incident reports, patient claims and litigations, process indicators of safety practices and relevant outcome measures. In 12 years we observed a sound increase of incident reports, a reduction of claims and some adverse outcomes (i.e. post surgical sepsis and thromboembolic events), a wide dissemination of safety practices. Thanks to the analysis of the compensation costs and the increased capacity to control and communicate risks, we decided to bring in-house the management of claims in 2010. Since then, we observed a slight decrease of the claims rate, a sound reduction of the time needed to finalize the compensation and estimated savings of 30 millions of euros per year.

At the national level, adverse events affect around 30,000 patients per year, the burden of compensation is around 1 billion of euros per year, while the costs of defensive medicine are estimated in 10 billions. For this reasons, the Italian Parliament approved on 28th February 2017 the law on patient safety and health professionals' responsibility, building on the pioneering experience of Tuscany. The law is an important innovation because it recognizes patient safety as a fundamental individual's right and at the same time offer a clear framework for safer practices, a safe space for reporting and learning and a fair compensation scheme.

Keywords: safety management, compensation, information system, patients' rights, claims management

Speaker information:

Tommaso Bellandi is a certified Ergonomist/Human Factors Engineer (Eur. Erg.) and a PhD in ICT.

He is the deputy director at the Centre for Clinical Risk Management and Patient Safety, within the Department of Health of the Tuscany Region in Florence, recognized as WHO collaborating centre in 2016.

He is Adjunct Professor of ergonomics and patient safety at the University of Florence (I) and at the Sant' Anna School of Advanced Studies in Pisa (I). He is author of more than 60 publications on Italian and international journals and books on patient safety, human factors and communication in healthcare.

Workshop 2: Global Patient Safety - Perspectives from Low- and Middle-income Countries (hosted by WHO)

This workshop, coordinated by the World Health Organization's Patient Safety and Quality Improvement unit, will focus upon low- and middle-income country perspectives on patient safety. The purpose of this workshop is to learn from countries on how to implement effective patient safety strategies to show demonstrable improvements, despite major constraints, barriers and limited resources. This cross-fertilization and transfer of knowledge provides an excellent opportunity for the critical appraisal of practices and cost-effective advancements in patient safety.

The workshop intends to provide opportunities for countries to learn from on-the-ground experiences, cutting across some of the most poignant themes in patient safety. The focus is on driving learning through an in-depth understanding of the development and effective implementation of innovative and cost-effective patient safety initiatives. Such practices can be adopted and adapted based upon local needs and contexts. The expected outcome of the workshop is to learn lessons from the successes and improvements in patient safety from low- and middle-income countries and develop key political messages for the Ministers of Health to seek their commitment and support in developing safer health care systems and improving patient safety.

Thema dieses mit der WHO koordinierten Workshops "Patientensicherheit global - Perspektiven von Staaten mittleren und niedrigen Einkommens" sollen internationale Aspekte der Patientensicherheit sein. Im Mittelpunkt werden der Erfahrungsaustausch über die Durchführung von Maßnahmen sein, die in Staaten mittleren und niedrigen Einkommens merkliche Verbesserungen der Patientensicherheit bewirkt haben. Darüber hinaus soll die Übertragbarkeit innovativer Ansätze zwischen Staaten erörtert werden, mit besonderem Augenmerk auf berufsübergreifende Ausbildung in Patientensicherheit, Ausbau von Führungskompetenzen, Politik und Verwaltungspraxis und Patientenbeteiligung.

Chair: Prof. Sir Liam Donaldson

World Health Organization, WHO Envoy for Patient Safety, Geneva, Switzerland

Chair Information:

Professor Sir Liam Donaldson is recognised as an international champion of public health and patient safety. He was the foundation chair of the World Health Organisation's World Alliance for Patient Safety, launched in 2004. He is a past vice-chairman of the World Health Organisation Executive Board. He is now the World Health Organisation's Envoy for Patient Safety, Chairman of the Independent Monitoring for the Global Polio Eradication Programme, as well as Chairman of the Transition Monitoring Board of this Programme. In the UK, he is Professor of Public Health at the London School of Hygiene and Tropical Medicine, Honorary Distinguished Professor at Cardiff University, Associate Fellow in the Centre on Global Health Security at Chatham House, and Chancellor of Newcastle University.

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Sir Liam initially trained as a surgeon in Birmingham and went on to hold teaching and research posts at the University of Leicester. In 1986, he was appointed Regional Medical Officer and Regional Director of Public Health for the Northern Regional Health Authority.

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Chair: Dr. Edward Kelley

World Health Organization, Service Delivery and Safety, Director, Geneva, Switzerland

Chair Information:

Dr. Kelley is Director for the Department of Service Delivery and Safety at the World Health Organization. In this role, he leads WHO's efforts at strengthening the safety, quality, integration and people centredness of health services globally and is the lead for WHO's work on strengthening health systems and security. Dr. Kelley has led health systems work within WHO's Ebola and Zika response teams and manages WHO's work in a wide range of programmes, including health services integration and regulation, patient safety and quality, blood safety, injection safety, transplantation, traditional medicine, essential and safe surgery and emerging areas such as mHealth for health services and genomics. Prior to joining WHO, he served as Director of the U.S. National Healthcare Reports for the U.S. Department of Health and Human Services in the Agency for Healthcare Research and Quality. Dr. Kelley also directed the 28-country Health Care Quality Improvement (HCQI) Project of the Organization of Economic Cooperation and Development. Formerly, Dr. Kelley served as a Senior Researcher and Quality Assurance Advisor for the USAID-sponsored Quality Assurance Project (QAP) and Partnerships for Health Reform Project Plus (PHRPlus). Prior to this, Dr. Kelley directed the international division of a large US-based hospital consulting firm, the Advisory Board Company. His work over two decades has focused on strengthening links between health security issues and the quality, safety and organization of health services, including metrics and measurement in health services and health systems improvement approaches and policies.

Co-Chair: Dr. Neelam Dhingra-Kumar

World Health Organization, Patient Safety and Quality Improvement Unit, Service Delivery and Safety Department, Coordinator, Headquarters, Geneva, Switzerland

Chair Information:

Neelam Dhingra-Kumar, MD, is Coordinator for the Patient Safety and Quality Improvement Unit, in Department of Service Delivery and Safety at the World Health Organization (WHO) headquarters in Geneva. In this role, Dr Dhingra leads WHO's efforts at providing strategic leadership on patient safety and quality improvement and strengthening system for safety and quality of health services globally. Dr Dhingra coordinates WHO's work for improvement of safety and quality of health care, including global patient safety challenge on medication safety, global networks, safety and quality tools and checklists, reporting and learning systems, patient and family engagement and patients for patient safety, leadership in patient safety and education and training. Since joining WHO in 2000, Dr Dhingra had been leading global initiatives for strengthening the delivery and safety of transfusion and laboratory services, as part of the broader health care system. Prior to that, Dr Dhingra served as a medical faculty in a large, tertiary care University Teaching hospital in New Delhi, India for 14 years. Dr Dhingra's areas of expertise are policy and strategy formulation; safety and quality of health services; vigilance, reporting and learning; quality and risk management; education and training; and assessments, monitoring, evaluation and operational research.

Bringing Transformational Changes in Safety Culture in Hospital Care

Jonás Gonseth García, Dr., Pan American Health Organization PAHO/WHO, Advisor Quality in Health Systems and Services, Washington DC, USA

Abstract:

Brief discussion based on real examples of components that have facilitated change and are potentially transferable to any critical hospital in low and middle income countries: conceptual framework of process management, enhancing transparency, patient engagement, clinical / staff leadership participation, outsider technical support as external experts and collaborating centers. A special emphasis on enhancing the vision of health care networks, in which the hospital plays a distinctive role, in the context of integration and continuum of care, empowering primary health care levels, implementation of sound initiatives that work as triggers for general improvement and strong political support for the Universal Health WHO framework.

Keywords: universal health, hospital, health care networks

Speaker information:

Jonás Gonseth, MD, MPH, PhD is a specialist practitioner in Preventative Medicine and Public Health by the Ministry of Education of Spain. He serves as Advisor, Quality in Health Systems and Services in the Pan American Health Organization, Regional Office for the Americas of the World Health Organization PAHO/WHO in Washington DC. He has extensive experience in Hospital and Primary Care Management in Ecuador and Spain. For more than ten years he has been an active advocate for Patient Safety Champions and Quality Improvement. He was also a member of the steering commit-tee for the IBEAS Study, a pioneering study on patient safety in Latin America.

Measuring and Improving Patient Safety in LMIC Primary Care Settings

Jeremy Veillard, Dr., World Bank Group, Program Manager, Primary Health Care Performance Initiative, USA

Abstract:

In the wake of the Ebola crisis, WBG researchers and operational staff sought to measure and improve infection prevention and control in health clinics. They immediately hit a snag—although patient safety in high-income country hospitals was relatively well researched, there was less information on primary care in low-income countries. In response, the group set up the Kenya Patient Safety Impact Evaluation or KePSIE project, with three aims:

(A) Develop new methodologies to collect data on patient safety from primary care settings in low-income countries;

(B) Together with the Kenyan government develop inspection tools and protocols for public and private health facilities and train a professional cadre of inspectors and;

(C) Evaluate the impact of such inspections on patient safety in these settings.

Over a 4-year engagement, many of the original goals have been met.

- The team piloted and led the largest existing survey of patient safety in primary care worldwide, the findings of which were recently published in the Bulletin of the WHO. Fully validated tools that can be used in other countries are ready for scale-up.
- Over 3 years, the team and the government developed an inspection checklist that was piloted for one year and then finalized over a 6-month collaborative revision process. A cadre of professional inspectors were trained and deployed and the checklist and the training process are now being scaled up through a WB project.
- The team has instituted a randomized evaluation of the inspection process slated for completion in 2019. This unique evaluation, when completed, will be the largest Randomized Controlled Trial of patient safety interventions in LMIC, focusing on the impact of regulations and inspections.

Team Members: Jishnu Das, Guadalupe Bedoya, Amy Dolinger, Njeri Mwaura, Khama Rogo, Jorge Coarasa, Ana Goicoechea, Frank Wafula,

Keywords: Patient Safety, Inspections, Primary Care, Public and Private

Speaker Information:

Jeremy Veillard, PhD, is the program manager for the Primary Health Care Performance Initiative at the World Bank. Prior to joining the World Bank, Dr. Veillard was the Vice President of Research and Analysis at the Canadian Institute for Health Information from 2010-2015. Dr. Veillard is also currently an Assistant Professor at the University of Toronto's Institute of Health Policy, Management and Evaluation in Canada and the past President of the Canadian Association for Health Services and Policy Research and was the chair of the OECD Health Quality Indicators Experts Committee from 2013 to 2015.

Engaging Patients, Family and Community for Safer and Higher Quality Care – Experiences from Uganda

Regina Kamoga, Executive Director-Community Health And Information Network (CHAIN) Uganda

Abstract:

CHAIN engages and empowers patients, families, the community and key healthcare stakeholders to improve the quality and safety of care in Uganda. This includes key issues such as improving people's and communities health literacy around hand hygiene, medication safety and injection safety.

Method:

- Raising awareness and sharing knowledge and experiences: SMS messages, public hearings, media campaigns, community events.
- Capacity development: Training for patient safety advocates and Community Safe Medicines Advocates (CSMAs).
- Multi-stakeholder collaboration: Key healthcare stakeholders including the Ugandan Ministry of Health, the National Drug Authority and the World Health Organization are engaged through frequent dialogues and workshops to improve relationships and to advocate for integration of patient safety into the national delivery systems.

Key results:

- Over 500,000 patients and families educated on safe use of medicines, injection safety, hand hygiene and health literacy;
- 200 patient advocates empowered to promote patient safety from cancer, epilepsy, sickle cell, HIV, Hepatitis B, and mental health organizations;
- 60 CSMAs trained to improve adherence and reduce adverse drug reactions;
- Ugandan Patients for Patient Safety (PFPS)network formed;
- Multi-stakeholder partnership meetings held twice a year.

Patients, families and communities are powerful resources for improving patient safety and quality. We need to prioritize a research agenda on engagement in LMICs, to understand facilitators and barriers to engagement for all stakeholders.

Keywords: Engagement, health literacy, community health, Uganda

Speaker Information:

Regina Kamoga is the Executive Director of CHAIN Uganda. She has over 10 years' experience working with patients, families and community. She has spearheaded several patient safety initiatives using innovative approaches such as SMS messages, public hearings, sports, music, dance and drama to reach the rural and hard to reach communities. In collaboration with the Ministry of Health, the World Health Organization, Regina organized a national Patients for Patient Safety workshop which culminated into a Ugandan network of patient safety advocates.

Building Competent and Compassionate Health Workforce for Safer Care – Experiences from Thailand

Piyawan Limpanyalert, Dr., Deputy CEO of the Healthcare Accreditation Insitute (Public Organization), Thailand

Abstract:

The Healthcare Accreditation Institute (HAI; Public Organization), Thailand, has conducted the "Engagement for Patient Safety" Project, aiming at improving healthcare service systems that provide safe and high-quality care under active participation of all key stakeholders.

Strategies included: (1) Share: creating forums to build relationships, experience-sharing and learning among key stakeholders. (2) Chain: building networks among key stakeholder through series of consultative meetings and workshops, and establishing Communities of Practices. (3) Shape: creating and shaping process for achievements to be specific and suitable for each institutional, hospital or local context. (4) Change: developing and strengthening safety culture in hospitals, using health system information, knowledge research for changes.

There were 148 hospitals, 150 healthcare experts, and 150,000 healthcare providers engaged in 11 Communities of Practices for patient safety. In addition, 133 training institutions participated patient safety curriculum development. Mutual memorandum of understanding on moving the patient safety curriculum forward was also signed by 8 health professional councils. There were 25 leaders of patient safety networks and 150 patient safety trainers were produced. Data and material center to collect all related documents, training guidelines and materials has also been established by HAI. Furthermore, a pilot project of interprofessional education (IPE) is now conducting by 3 universities.

Engagement of key stakeholders to share and learn together is a key strategy for patient safety improvement. Creating of safety culture environment as well as establishing an educational resource center are also helpful for continual improvement.

Keywords: engagement, patient safety, curriculum, inter-professional, education

Speaker Information:

Dr. Piyawan Limpanyalert is the Deputy CEO of the Healthcare Accreditation Institutes (Public Organization), who has experiences in hospital management and quality improvement for > 15 years. She is also an expert in organizing and establishing Communities of Practice for healthcare system by facilitating stakeholders to share knowledge and experiences and to identify good practices. In collaboration with WHO, she has developed an umbrella of Engagement for Patient Safety, which includes 3 programs: Patient Safety Education, Patients for Patient Safety, and Safe Hospital.

Developing Patient Safety Systems – Experiences from Croatia

Jasna Mesarić, Assoc. Prof., MD, PhD, Agency for Quality and Accreditation in Healthcare and Social Welfare, Assistant Director, Department for Quality and Education, Croatia

Abstract:

Patient safety is a priority on the Croatian health system agenda. There is no formal national patient safety policy document, but it is integrated in the respective legal framework and National Healthcare Strategy 2012-2020. Activities are also related to the Council of Europe Recommendation on patient safety including prevention and control of healthcare associated infections (2009).

Patient safety activities are mostly focused on hospital setting. Agency for Quality and Accreditation in Healthcare and Social Welfare (AQAHS) has established a system of collecting data on sentinel events (2012), patient safety indicators (2013) and compliance with mandatory quality standards including patient safety. Annual reports are found on AQAHS website. The WHO Patient Safety Curriculum has been translated into Croatian and its implementation in health professional training is planned this year. Implementation of WHO SCL started in 2008, and has been integrated in hospital in-formation system of 6 hospitals (pilot project 2015). In the frame of EU JA PaSQ project, Medication Reconciliation has been initiated in 14 hospitals (2014). National policy for antibiotic resistance control in line with WHO Recommendation has been updated (2017-2021). Standardized trainings for emergency medical service professionals have been conducted by Croatian Institute of Emergency Medicine (2012). Electronic prescription system in general practice is in place. Additional improvements in primary healthcare are planned (safety culture survey). Electronic medical record is under development.

Education and training in patient safety are necessary to achieve respective competences at the national level and to increase awareness of the issue among stakeholders involved.

Keywords: patient safety, healthcare system, Croatia

Speaker Information:

Associate Professor at the University of Zagreb School of Medicine and Assistant Director, Quality and Education, Agency for Quality and Accreditation in Healthcare and Social Welfare, Croatia.

She is specialized in transfusion medicine with postgraduate qualification in Hematology, Clinical Pediatrics and Leadership and Management of Health Services. She is president of the Croatian Society for Quality Improvement in Healthcare, Croatian Medical Association, and European Society for Quality in Healthcare (ESQH). She had a leadership role in launching WHO PATH (Performance Assessment Tools for Hospitals) program in the framework of BCA-WHO and Ministry of Health. Through years, she has been active in a wide range of issues and initiatives associated with the implementation of quality standards, quality measurement and improvement. She was Managing Director of AQAH (2013-2014). She is currently engaged in education on quality and patient safety as well as in the research in medication reconciliation implementation.

Strengthening Implementation of Patient Safety Policies on Incident Reporting and Learning System – Experience from Malaysia

Nor'Aishah Abu Bakar, Dr., Consultant Public Health Physician, Senior Principal Assistant Director; Head of Patient Safety Unit, Medical Care Quality Section, Medical Development Division, Ministry of Health, Malaysia

Abstract:

In Ministry of Health Malaysia, "Incident Reporting", "event monitoring" or "occurrence reporting" was first introduced in 1999 as part of Quality Assurance and Risk Management tool. Nevertheless, the approach was on local level implementation and improvement. In 2011, a specific policy from the Director General of Health Malaysia on "Incident Reporting (IR) and Learning System" was produced as part of Patient Safety initiative to learn from error and improve the healthcare system. In 2013, IR was also included as part of Country Policy on Patient Safety called Malaysian Patient Safety Goals. Root Cause Analysis (RCA) was also introduced as investigation tool to identify system issues in the healthcare organization in more structured and holistic manner. A three- tier reporting and monitoring using 100% manual system was also introduced (i.e. from healthcare facilities to State Health Department and to Ministry). However, this system was perceived as complicated by hospitals. Hence, in 2016, a policy on the use of online system, "e-IR" was produced to replace certain part of the manual system. This "e-IR" was created using a "free software". "Basic Information on Incident" was reported online, directly to Patient Safety Unit at Ministry level. The benefits are: (1) More user friendly (2) Data analysis is done centrally by Ministry which allows: (i) More comprehensive detail monitoring of the country incidents (ii) Comparison between various States and Hospitals (iii) Detail analysis of Incident profiling (iv) Nationwide report using big data to identify problem areas in patient safety (v) National policy or programme based on common identified issues (3) Reduce the work burden of State Health Department to conduct analysis. This allows them to focus more on assisting hospitals in improvement effort following incident. A standardised template of RCA Report to improve the quality of report and enable extraction of information for more objective analysis at Ministry level was also created. After a year of implementation, we can see that the combination of specific policy on Incident Reporting and the use of Information Technology have both managed to strengthen our Incident Reporting and Learning System.

Keywords: Patient safety policy, Incident Reporting, Information Technology

Speaker information:

Dr. Nor'Aishah Abu Bakar is a Consultant Public Health Physician who is the Head of Patient Safety Unit, Ministry of Health Malaysia. She is a Patient Safety Champion who is very passionate in improving patient safety through policies, programmes, capacity building, creativity and engagement. Among her main contributions in Malaysia are the establishment of Safe Surgery Saves Lives in 2009, implementation of Malaysian Patient Safety Goals since 2013, establishment of PATIENTS For Patient Safety Malaysia in 2013 and Mandatory Patient Safety Course for House Officers in Malaysia since 2017. She is also the Chairperson of TWG on Incident Reporting and Learning System and currently working with her team to strengthen the existing system which is more comprehensive and user friendly. The tag line of the organisation is "Patient Safety Unit…With Care and Compassion".

Implementing WHO Safe Childbirth Checklist for Safer Maternal and Neonatal Care – Experiences from Sudan

Ayda Abdien Hago Taha, Dr., Head of Patient Safety Program at Directorate General of Quality, Federal Ministry of Health, Sudan

Abstract:

Maternal and neonatal health (MNH) is a global priority. In many parts of the world, efforts put into reaching the targets of Millennium Development Goals have fallen short. Therefore, WHO developed a Checklist to help bridge the gap between healthcare providers' knowledge and practice. In 2012, the WHO Safe Childbirth Checklist Collaboration was established to test the global usability of the Checklist. Since MNH is a national priority in Sudan, our team decided to participate in the Collaboration. This is a pre- and post-intervention study to determine the applicability of the Checklist and its effect on healthcare provider practices. Study Population consists of healthcare providers which included midwives, interns, medical officers and residents. The health system in Sudan is decentralized, hence advocacy and engagement of leaders at Khartoum State Ministry of Health and in the Hospital was necessary. After approval, data collectors were trained to observe healthcare provider practices before and after they were trained on using the checklist. At the end of the study, two Focus Group Discussions were held to establish the benefits, areas of weaknesses, lessons learnt and suggestions of modifications to the checklist. Pre-intervention: 402 births (normal vaginal deliveries (NVDs) and C-sections) were observed before introducing the Checklist. Overall, practice in C-sections was better than NVDs. Areas of weaknesses were identified. The hospital was then given a period of time to address these issues. Post-intervention: 427 births were observed. Midwives used the Checklist in 98% of the childbirths and it showed a significant improvement in 4 out of 6 practices. Doctors used the checklist in around 15% of NVDs which also showed a significant improvement in 15 out of 18 practices. Finally, Newborn feeding assessment significantly improved from 26% to 54%. Introduction of the Checklist significantly improved the delivery of best practices by healthcare providers in 20 out of 25 practices. Adherence was closely related to the presence of a motivated key figure. Furthermore, the checklist improved communication amongst the clinical team and acted as a useful reminder in times of rush. Checklists in general are reminder tools used to help deliver best care practices. However indirectly, it was useful in reflecting weaknesses in the hospitals system. For example, lack of policies and procedures, lack of training in hand hygiene and unavailability of supplies. Therefore, for the checklist to provide the desired outcome, it needs to be supported by a conductive environment. This can only be attained by conducting an assessment of the facility and addressing the identified missing elements before introduction of the checklist.

Keywords: Safe Childbirth Checklist, Best Childbirth practices, Safe Maternal care, Safe Neonatal care

Speaker Information:

Dr. Ayda Taha is the Head of Patient Safety directorate at Federal MoH in Sudan. She was part of the team to establish the National Patient Safety, Infection Prevention and Accreditation Programs. She is the focal point for implementing EMRO's Patient Safety Friendly Hospital Initiative and WHO's Patient Safety related initiatives. Dr.Ayda contributed in the development of the Patient Safety Module for the post graduate curriculum in Sudan's Public Health Institute. She is also a lecturer delivering sessions in Patient Safety in several academic institutions. Supervised by: Dr. Elmuez Ahmed Eltayeb, Director General of PHC, FMoH, Sudan

Workshop 3: Patient Safety and mHealth, Big Data, and Handheld Devices

Mobile technologies (mHealth, handheld devices) and also technologies to process big datasets (Big Data) are gaining worldwide importance in the field of health, and in a tremendously fast manner. With the aid of mHealth, patient safety may be strengthened, especially by improved patient information and adherence as well as by increasing self-determination. Big Data applications hold the promise of more efficient methods of successful treatment by evidence-based and personalised procedures in health care. Opposed to this are the risks concerning e.g. data safety and product quality. Although patient safety is quoted as the key reason and goal of capital investment in those technologies, the purposeful application and analysis of the latter to reach the established goals of patient safety have not yet been sufficiently developed and networked at international level. In this regard, the workshop is supposed to provide solutions. Against this background, one of the key points of emphasis will be patient safety in connection with non-medical health apps, and attention should be paid to the necessary information of customers/patients, transparency and the role of web stores.

Mobile Technologien (mHealth, Handhelds) sowie Technologien zur Verarbeitung großer Datenmengen (Big Data) gewinnen im Gesundheitsbereich weltweit und in rasanter Geschwindigkeit an Bedeutung. Mittels mHealth könnte man Patienteninformationen verbessern sowie Adhärenz und Selbstbestimmung fördern, aber dem stehen auch die Risiken für den Datenschutz und die Produktqualität entgegen. Big Data-Anwendungen und der Zugang zu Datenmengen nähren die Hoffnungen auf Fortschritte in der evidenzbasierten und personalisierten Gesundheitsversorgung. Patientensicherheit ist eine der Haupttriebfedern für Kapitalinvestitionen in diesem Technologiezweig. Jedoch steckt ihr Ausbau und die internationale Vernetzung ihrer Anwendungen noch in den Kinderschuhen. Einer der Aspekte wird die führende Rolle der Patienten/Verbraucher in der technischen Weiterentwicklung von mHealth, insbesondere im nichtmedizinischen Bereich sein.

Chair: Dr. Mike Durkin

NHS National Director of Patient Safety, United Kingdom

Chair Information:

Dr Mike Durkin is the NHS National Director of Patient Safety at NHS Improvement. Prior to this appointment he was the Medical Director of the South of England Strategic Health Authority having previously held Executive Medical Director positions at Strategic Authorities and at Gloucestershire Royal Hospital. He qualified at The Middlesex Hospital and has held research and teaching appointments in London, Bristol and Yale University. He has led performance and governance reviews in the UK and overseas. He was the National Clinical Director for Venous Thrombo-Embolism, is an appointed Expert by the International Society for Quality in Healthcare and was on the core team for the Patient Safety Campaign for England. He leads the National Patient Safety Programme for England and supports the international development of patient safety systems. He convened the Berwick Advisory Board to advise on creating the conditions to improve the safety of patients in England and he was Chair of the Expert Advisory Board that advised the Secretary of State for Health on the establishment of the Healthcare Safety Investigation Branch. He is Chair of the Management Board of the NICE National Clinical Guideline Centre and sits on research, policy and patient safety Advisory Boards. He holds Visiting Professor appointments at Imperial College, London and the University of the West of England. He is an Associate Non-Executive Director at the NHS Litigation Authority.

Prof. Lord Ara Darzi

Professor the Lord Ara Darzi of Denham OM KBE PCFRS HonFREng FMedSci, Professor of Surgery, Imperial College London, United Kingdom

Speaker Information:

Professor Darzi is director of the Institute of Global Health Innovation at Imperial College London and holds the Paul Hamlyn Chair of Surgery at Imperial College London and the Institute of Cancer Research. He is Executive Chair of the World Innovation Summit for Health in Qatar. He is a Consultant Surgeon at Imperial College Hospital NHS Trust and the Royal Marsden NHS Trust.

Professor Darzi is the director of the NIHR Imperial Patient Safety Translational Research Centre, a collaboration between Imperial College Healthcare NHS Trust and Imperial College London. The Centre has a decade-long track record of undertaking high-impact translational research in patient safety and was recently awarded £7.3 million by the NIHR for the next five years. In March 2016, the NIHR Imperial PSTRC co-hosted the first Patient Safety Global Action Summit with the UK Department of Health.

He was knighted for his services in medicine and surgery in 2002. In 2007, he was introduced to the United Kingdom's House of Lords as Professor the Lord Darzi of Denham and appointed Parliamentary Under-Secretary of State at the Department of Health. He has been a member of Her Majesty's Most Honourable Privy Council since June 2009. In January 2016, Professor Darzi was awarded the Order of Merit by Her Majesty the Queen for exceptionally meritorious service towards the advancement of medicine.

Protecting Patients and Encouraging Innovation: The Role for Regulation

Margaret A Hamburg, MD, Foreign Secretary. National Academy of Medicine, USA

Abstract:

Advances in science and technology are combining with new insights into the nature of disease management, prevention and health promotion to offer a remarkable new array of opportunities for health and health care, Mobile technologies, including hand held devices and mobile apps, represent a particularly exciting new arena of activity, enabling patients to have direct access to/control of their own health information, while also supporting doctors ability to diagnose and manage care outside of the healthcare setting. New capabilities in bioinformatics and "big data" provide further opportunities to improve health care and deepen our understanding of disease and wellness. Moving forward, however, these potential advances must be aligned with efforts to adequately assess safety, efficacy, quality and performance of these approaches. In the context of medicine and public health, innovation only really matters if it benefits patients and consumers. New mobile and/or software driven technologies can span a broad range of health issues, many carrying minimal risk. Yet others may pose considerably more concern, and could be truly harmful to patient safety and consumers if they do not work properly. Thus we must work together to strike the right balance, based on evidence and experience, that will enable us to both assure patient/consumer safety and encourage innovation.

Keywords: Medical apps, regulation, patient safety, innovation

Speaker Information:

Dr. Hamburg is the former Commissioner of the FDA, known for advancing regulatory science, as well as streamlining and modernizing regulatory pathways. As Foreign Secretary of NAM, Dr. Hamburg is senior advisor on international matters and liaison with other Academies around the world. She is President-elect of the American Association for the Advancement of Science, sits on several not-for-profit boards/ advisory committees, and has received numerous awards and honorary degrees. Dr. Hamburg graduated from Harvard College and Harvard Medical School.

Using Artificial Intelligence to Prevent Healthcare Errors from Occurring

Nicolaus Henke, Dr., McKinsey & Company, Senior Partner, UK

Abstract:
Artificial intelligence is reshaping how performance and quality is managed in many of the world's most advanced sectors and organizations - from telecommunications to high performance sports to healthcare. The big cross-industry trend to discover specific risks in order to prevent failure. If executed well through the "last mile", the lift above transitional techniques can be 60-90% reduction.

We will share a few specific examples how this can be applied to performance and safety in three areas in healthcare: 1. Clinical decision making, for example determining the mix and dosage for AIDs/HIV patients, or diagnosing specific cancers. 2. Improving clinical operations, for example identifying root causes for safety risks to support case prevention or regulatory action. 3. Predicting risk in patients to enable timely and more focussed preventative action, for example to make cancer screening more targeted and effective or to avoid hospitalizations.

To capture this opportunity, health systems should enable population data linkage at scale; build analytical, technology and data management capabilities; and heavily invest into trans-forming last mile implementation capabilities.

Keywords: Artificial Intelligence, QuantumBlack, Patient Safety

Speaker Information:
Nicolaus Henke is a Senior Partner at McKinsey & Company. He is the global leader of McKinsey Analytics and has led McKinsey's Health Systems and Services Practice globally for the last decade. He has practical experience from servicing healthcare payors, regions, hospitals, and governments in more than 40 countries. He is serving various governments and national systems on overall health system reform and their information strategy, as well as their approach to life sciences.

Nicolaus is the Chairman of QuantumBlack, an Artificial Intelligence company serving clients in healthcare, 10 other industries, and high performance sports. He serves on the Board of the Innovative Healthcare Delivery at Duke Medicine, which he also helped found. He is on the Dean's Advisory Council, Harvard Kennedy School and serves on McKinsey's global Board, the Shareholders Council.

CRAB™: Big Scale – Routine Data as First Alert

Ingo Gurcke, Dipl. Kaufmann (FH), Marsh Medical Consulting GmbH, Managing Director, Germany

Abstract:

Statistical tools and general proxy measures, such as death and readmissions rates, have been the long-standing quality metrics in the absence of anything more sophisticated. These may work at a national or regional level for general planning, but neither necessarily give a true picture of local clinical quality, as insufficient account is taken of the types of patients clinicians have to treat. CRAB™ is the result of thirty years of research and development, and automates the POSSUM audit methology for risk adjustment and assessing clinical performance against case-mix. Assessments of clinical quality and performance can be reached with a reliable evidence base, and the raw data may be reviewed by drilling down to individual cases in the risk report. CRAB™ is a peerless benchmarking application, referencing a growing data-set of clinical variables drawn from more than 24 million anonymized records. 65 % of these data are UK-based, ensuring benchmarking of NHS practice is relevant and accurate. CRAB™ is unique in predicting the clinical risk for every individual patient, rather than making blunt assumptions based on national statistics. Using a pioneering methodology, clinical outcomes are adjusted for the case-mix complexity of every patient treated. The resulting analysis goes beyond crude mortality metrics, enabling the management to understand morbidity and avoidable harm across the organization. It is the only system to risk-adjust for complications as well as mortality, and to calculate risk-adjusted length of stay. The patient-level analysis is going beyond DRG-level coding and producing immediate root-cause analysis data with-out the need to review patients´ notes. At some hospitals, CRAB™ dropped complaints and litigation by more than 10 % and provides a fair, representative system for monitoring. It demonstrates the quality of patient care and enables quality measurement in real-time via a web-based system using the hospital´s own coding data that are collected automatically.

Keywords: Benchmarking, Identify Weaknesses automatically, Demonstrate Quality, Predict Risk, reduce avoidable harm

Speaker Information:

As Managing Director at Marsh Medical Consulting GmbH in Detmold, subsidiary of Marsh & McLennan Companies, New York, I educate clinical employees concerning patient safety to ameliorate communication between clinicians, treatment teams and patients. Master Thesis of my studies (Business Administration and Management at the University of Cologne) was the Implementation and Development of Risk Management in Hospitals. As member and deputy manager of Aktionsbündnis für Patientensicherheit e.V., we implemented the WS “Critical Incident Reporting Systems” (CIRS). With APS e.V. WS “Clinical Risk Management Systems”, we developed the minimum requirement to clinical risk management systems in hospitals in Germany; as member of GQMG e.V. and of Deutsche Gesellschaft für klinisches Prozessmanagement e.V. I am responsible for the digital education. I have founded the degree course of studies “Healthcare Risk Management (HRM)” with Technische Universität München (TUM) where I am assistant professor.

Digital Companions for a Sheltered Way: mHealth & Big Data

Kurt J.G. Schmailzl, Prof. Dr. Dr., Medizinische Hochschule Brandenburg: Health Care Research, ccc. Center for Connected Health Care UG, Germany

Abstract:

Networked care is a clue for patient safety and should be conceived as a paradigm shift in care. 'Digital and analogue companions for an ageing population (digilog)' is a joint research and development project in Brandenburg, testing a multitude of patient-side variables made-to-measure for subgroups at risk. Networked care will be outlined with regard to feasibility (monitoring, transmitting, and interpreting of physiological data), user-network interfaces (patients, medical professionals), and perspectives (personalized risk management).

mHealth should address the challenges of demographic trends and jeopardized care in laggard regions as well as shortcomings due to sectoral break lines and add something new to it (real-time physiological data, extension of care to preventive and rehabilitative measures, self-empowerment of the patient). IT-assisted tools for patients at risk are made up of digital companions, mainly external, some internal (implanted, such as pacemakers). The objective is to build a mobile, virtual drop-in clinic.

The technique brought to the patient must not interfere with everyday life, best, should not even be perceptible.

As data available from mHealth is increasing on a large scale, not only by volume but also by type, the challenge is to process the data overload and at the same time linking data of different types in a medically meaningful manner. This will require methods of machine learning and an AI approach which will be addressed, too, in the digilog project.

The boundaryless hospital, made real by IT-assisted tools, needs the self-empowered patient; combined with old-fashioned, 'analogue' companions (either in the shape of a district nurse or physicians controlling the implications of automated analyses), mHealth and big data could pave a sheltered way.

Keywords: Networked care • Self-empowerment • Virtual drop-in clinic • mHealth • Boundaryless hospital • Patient-centered workflow • Digital companions

Speaker Information:

Education in physics, medicine, and Social Sciences. Professional and scientific fields of expertise: international health management; wearable and implanted biosensors, e/mHealth; medical ethics, society-born diseases, health inequities, health care research. Current academic areas of expertise: 'Boundaryless Hospital', networked care, renewal of social care systems, health services contract management.

Bioethical Principles in mHealth and Big Data

Christiane Woopen, Prof., University of Cologne, Executive Director CERES, Germany

Abstract:

mHealth and Big Data promise major improvements in prevention, therapy and monitoring disease. At the same time there is hardly any control, certification or transparency with regard to the thousands of health apps that can be downloaded in app stores for everyone. Very often they are “for free” which means that users, whether patients or just users, pay with their data.

From an ethical point of view there are major challenges for patient safety, autonomy and privacy coming with the magnitude and variety of offers. These cannot be solved by national legal regulations only but need global multi-level ethical governance. All actors in the field like politicians, health professionals, IT-experts, companies, patient organizations, health insurance, developers etc. will have to stick to certain rules in order to maximize the possible benefits of mHealth and Big Data while at the same time avoiding harm for the user. The user´s and patient´s fundamental rights to safety, autonomy and privacy have to be respected. In times of Big Data this only seems to be possible by an ethical framework that guarantees the protection against poor quality and intransparency and the possibility of trust.

Patient safety needs the assumption of responsibility by all stakeholders in a shared approach of a multi-tiered ethical governance on a global scale.

Keywords: patient safety, autonomy, privacy, transparency, ethical governance

Speaker Information:

Christiane Woopen is Professor for Ethics and Theory of Medicine at the University of Cologne. There she is Executive Director of the Cologne Center for Ethics, Rights, Economics, and Social Sciences of Health (CERES). She is as well Head of Research Unit Ethics at the University Hospital Cologne. As a coordinator and principle investigator of several international and national research projects her research focuses on ethical aspects of reproductive medicine, neuroethics and digital autonomy. She is former chair of the German Ethics Council, President of the 11th Global Summit of National Ethics/Bioethics Committees 2016 and amongst others member of the International Bioethics Committee of UNESCO. Prof. Woopen received her medical degree from the University of Bonn and worked in gynecology and obstetrics before focusing on bioethics.

What can Start-ups and Developers do and what do they need to Improve Patient Safety?

Peter Langkafel, Dr. med. MBA, Healthcubator, CEO, Germany

Abstract:
Building innovative digital software solutions in healthcare should reflect the specific needs of patient safety. The different dimensions of safety should be integrated at the beginning of a project as well as during the process of developing, testing and deployment. The main 3 dimensions are:

1. Using state of the art technical tools to protect and safe patient data / medical data. This includes encryption and a clear concept of data administration not only of start-ups but of healthcare institutions.

2. Inform and engage the User: A user centric and "understandable" explanation of the services should be integral part of the solution. This includes the options of scalable dimensions of "giving and sharing data". We should not neglect that some business models are not based on private payments – but other are based on data handling. An emancipated patient should be able to decide himself about pros and cons.

3. Digital innovators in healthcare need a clear framework - "big data yes but not big grey zones". This includes data security, medical product regulations and needs for proof of evidence as well as defined market access strategies instead of "muddling through" to become part of the core healthcare system and being paid by insurances and governmental health systems.

Keywords: Digital Health, Innovation, Start-ups

Speaker Information:
Peter Langkafel has experience in healthcare / IT since more than 20 years.

He is CEO and founder of Healthcubator in Berlin – a company focused on health solution and president of the Berlin / Brandenburg sections of Germans Society of Medical Informatics e.V. (NGO)

He holds an PHD in medicine, a degree of "Medical Informatics" and an executive MBA (focused on Health Care Management).

After his clinical work at a University hospital he conducted a series of IT-Projects in Medicine including the project management of national and European research projects. He was head of the „strategic business development unit" of the Charité, university hospital of the Humboldt-University in Berlin / Germany.

Until 2015 he was General Manager Public Sector / Healthcare in Central Europe of SAP AG.

The Vast Amount of Apps for Diabetics – Comparing the Incomparable

Stephan Kern, Dr. med., Dr. Kern - Diabetologische Schwerpunktpraxis, Head and Senior Physician, Germany

Speaker Information:

Dr. Stephan Kern has long year experiences as practicing physician. He shows especially qualification in diabetology, sports medicine and nutrition therapy. Since several years he is an established doctor and a specialized diabetologist with responsibilities for diabetological quality circles. Finally he is active member of several chambers of physicians. In the last years he has increasingly focus on the feasibility and benefits of Apps in a diabetes therapy.

The Model of a Corporative Evaluation of Diabetes-related Apps – a Way to Achieve Better Patient Safety or just another Seal?

Veronika Strotbaum, ZTG Zentrum für Telematik and Telemedicine GmbH, Project manager, Germany

Abstract:

With around six to eight million affected patients, Diabetes is a serious problem for the German Health Care System, Due to the high importance of data and patient`s compliance in the therapy of diabetes, the use of mobile applications seems to be an adequate way to help patients and to make the therapy more flexible. Patients and professionals find hundreds or even thousands of diabetes-apps in the stores, which achieve a different level of quality. Because of this, it is very complex to choose a safe diabetes-app. Due to this problem, ZTG GmbH and the expert associations for Diabetes – DDG, DDH, DDH-M and VDBD – try a cooperative evaluation within the framework of a systematic criteria catalogue. App-Developers, which fulfil main criteria, get a corresponding certificate. Of course, there are already some initiatives, which certify health-related apps. The special of this certification is the throughout Germany unique cooperation between diabetes-correlated expert associations, self-help organizations and a more technique-orientated institution such as ZTG. The results generate more transparency in this field and help professionals and especially patients, to choose safe apps and to distinguish between apps high in quality and health-related “gimmicks”. This model could be also a role model for the cooperation of ZTG with other expert- and patient-organizations. The advantage of this corporative evaluation is the integration of different perspectives and competencies, especially in the field of the often neglected medical and usability questions.

Keywords: diabetes, mobile apps, cooperation, transparency

Speaker Information:

Veronika Strotbaum, Gerontologist and MA in Management in Healthcare Systems, works as a project manager at Zentrum für Telematics and Telemedicine. Her main areas of interest are telemedicine, methods of evaluation, mHealth/Mobile Apps and Consumer Health Informatics. Commissioned by the local government of NRW, she develops, in cooperation with national expert and patient associations, concepts to select safe mHealth-applications and to provide the knowledge in a publicly accessible way.

Users' Needs when Confronted with a Product Overflow

Ilona Köster-Steinebach, Dr., Policy Officer, Federation of German Consumer Organisations (vzbv), Germany

Abstract:

The following points are not the results of a specific study, but interpretations developed from market observation with a special focus on problems of consumers and patients. They are also based on the information collected by the Federation of German Consumers Organizations when participating in the political process of providing the members of the German statutory health insurance with safe and free of charge access to E-health products.

Consumers and patients are confronted with a multitude of products and apps when they want to use E-health to help solving their medical problems. They differ greatly concerning their health literacy, but also with respect to their knowledge and preferences in the digital world. Only very few consumers/patients are willing and able to check on the chosen products whether they are reliable, correct, safe and provide adequate data protection. Unless a product is registered under the medical device regulation – and only a bare handful are – there is no distinguishing mark or label that signals the consumers/patients the quality of e.g. a health app. Nevertheless there are quality features that are essential for patients/consumers:

- Usability
- Medical functionality
- Safety concerning reliability of service, possible medical side effects or simple errors
- Interoperability with other forms of health care
- Transparency of data use and storage; profound consumers rights to decide upon the re-use of data concerning their person, privacy protection
- Producer liability

Such features are not for free, so products meeting these criteria will necessarily be more expensive than low-quality products. To create a market for high quality E-health products market regulation should provide a label or other means to distinguish products according to quality.

Keywords: Consumer needs, quality criteria for E-health products, market transparency & regulation,

Speaker Information:

Dr. Ilona Köster-Steinebach: Born 1971. Master degree in Japanese Studies, Ph. D. in economics. 13 years of working experience in German healthcare, 7 of which as policy officer for quality and transparency in healthcare at the German Federation of Consumer Organisations. Since 2010 active in representing patients interests at the German Federal Joint Committee specializing on patient safety issues.

Workshop 4: Prevention and Control of Infectious Diseases

The central issue of the workshop will be the discussion of measures to prevent infections, in particular in the context of nosocomial infections and sepsis, but also to reduce the use of antibiotics, thus avoiding antimicrobial resistance. On this occasion it shall be examined to which extent national recommendations on infection prevention can also be applied at international level, and particularly in low- and middle-income countries. Along the discussion of strategies for implementing recommendations for action, aspects such as costs incurred by nosocomial infections and the involvement of patients within the scope of infection prevention will be covered.

Zentrales Thema soll die Diskussion von Maßnahmen zur "Infektionsvermeidung" insbesondere im Kontext nosokomialer Infektionen und Sepsis aber auch zur Reduktion der Notwendigkeit des Antibiotika-Einsatzes und dadurch der Vermeidung von Antibiotika-Resistenzen sein. Dabei soll untersucht werden, inwiefern sich nationale Empfehlungen zur Infektionsvermeidung auch international und insbesondere in Staaten mit mittlerem und niedrigem Einkommen umsetzen lassen. Neben Implementierungsstrategien für Handlungsempfehlungen sollen auch Aspekte wie Kosten durch nosokomiale Infektionen und die Beteiligung von Patienten im Rahmen der Infektionsprävention diskutiert werden.

Chair: Prof. Dr. Petra Gastmeier

Charité – University Medicine, Head Institute of Hygiene, Germany

Chair Information:

Petra Gastmeier was certified as a specialist in Hygiene and Environmental Medicine in 1988. Following several years working as a senior physician at the Institute of Hygiene of the Free University Berlin she was appointed as an associate professor at Hanover Medical School and head of the Division of Hospital Epidemiology in 2000. Since 2008, she is head of the Institute of Hygiene and Environmental Medicine, Charité – University Medicine Berlin.

She is an expert in surveillance of nosocomial infections and antimicrobial resistance. She has published more than 350 scientific papers and review articles in this field. She is coordinating the work of the German Nosocomial Infection Surveillance System (called KISS) with data from more than 1400 German hospitals. She is also responsible for the current German national hand hygiene campaign with more than 1000 hospitals participating.

Co-Chair: Prof. Dr. Lindsay Grayson

Austin Health, University of Melbourne, Director, Infectious Diseases & Micro-biology, Director, Hand Hygiene Australia, Australia

Chair Information:

Prof. M. Lindsay Grayson, MB BS, MD, MSc (Harvard), FRACP, FAFPHM, FRCP (Edin), FRCP, FIDSA

Prof. M. Lindsay Grayson is Director, Infectious Diseases & Microbiology Department at Austin Health; Professor of Medicine, University of Melbourne and Professor (Hon) in the Department of Epidemiology & Preventive Medicine, Monash University, Melbourne, Australia.

Dr. Grayson is also Director of Hand Hygiene Australia, the national body responsible for improving and assessing rates of hand hygiene compliance among healthcare workers in Australian hospitals and for the regular reporting of these results on the Australian Government's national MyHospitals website.

He is the past-President of the Australasian Society for Infectious Diseases and past-Chair of the ICAAC (Interscience Conference on Antimicrobial Agents and Chemotherapy) Program Committee, American Society for Microbiology.

Dr. Grayson has authored over 180 peer-reviewed articles, is Editor-in-Chief of the textbook "Kucers: The Use of Antibiotics" (7th ed) and is on the Editorial Board of Clinical Infectious Dis-eases (USA).

Dr. Grayson's main research interests include issues associated with antibiotic resistance, appropriate antibiotic use in humans (and animals), infection control and practical "culture change" initiatives in healthcare.

Co-Chair: Prof. Dr. Martin Mielke

Robert Koch-Institute, Head of the department for infectious diseases, Berlin, Germany

Chair Information:

Martin Mielke is head of the department for infectious diseases at the Robert Koch-Institute (Germany). He is a clinical microbiologist and immunologist and is interested in the prevention of nosocomial infections as well as in strategies to prevent the spread of antimicrobial resistant bacteria. He is involved in the development of national best practice guidelines and strategies to minimize the risk for infections including those with MDR bacteria. Several national reference centers are part of the department.

Impact of Healthcare-associated Infections in Europe: Results of a Population Prevalence-based Modelling Study

Alessandro Cassini, Expert Antimicrobial Resistance and Healthcare-associated Infections, European Centre for Disease Prevention and Control, Sweden

Abstract:

Estimating the impact of healthcare-associated infections (HAIs) is challenging due to the need for good quality data on the incidence of HAIs and on the co-morbidities of hospitalised patients. We estimated the burden, expressed in disability-adjusted life years (DALYs), of six common HAIs included in the 2011-2012 ECDC point prevalence survey (PPS) accounting for more than 2.5 million cases of HAI occurring in acute care hospitals in the European Union and European Economic Area (EU/EEA). The attributable risks related to HAIs were based on systematic literature reviews and severity groups and were used to estimate reductions in life expectancy.

The estimated cumulative burden of the selected six common HAIs in the EU/EEA (501 DALYs per 100,000 general population) was higher than the total estimated burden of 32 communicable diseases under surveillance at ECDC (BCoDE 2009-2013, 260 DALYS per 100,000 general population). Healthcare-associated pneumonia and healthcare-associated primary bloodstream infections represented more than 60% of the total DALYs from the selected HAIs. The results were based on a subset of HAIs and only in acute care hospitals; when considering long-term care facilities, HAIs may double in number and consequently DALYs would also increase.

Despite being an underestimation of the burden of HAIs, our results highlight the high burden of HAIs for the EU/EEA. Considering that half of the cases would be preventable through properly implemented infection prevention and control measures, the study indicates the need for increased efforts for their prevention and control. Furthermore, our model should allow for estimation of the potential impact of preventive measures on the burden of HAIs in the EU/EEA.

Keywords: Burden of disease, healthcare-associated infections, disability-adjusted life years

Speaker Information:

Alessandro Cassini is a medical doctor specialized in public health and epidemiology. After an MSc in Health Policy Planning and Financing from London School of Economics and London School of Hygiene and Tropical Medicine, he joined ECDC and led ECDC's Burden of Communicable Diseases in Europe (BCoDE) project. This project has the remit of estimating and expressing the health burden of communicable diseases and related conditions, including exploring ways to bridge the communication and technical gap between risk assessors and managers (knowledge translation) and ultimately enhance informed and evidence-based health policy decision-making. This methodology was subsequently applied to the estimation of the burden of healthcare-associated infections (HAIs). Occasionally, Dr. Cassini goes back to the field and has been involved in ECDC's contribution to the Ebola response effort.

WHO Core Components for Infection Prevention and Control

Benedetta Allegranzi, Prof., MD, Coordinator, infection prevention and control Global Unit, WHO HQ (Service Delivery and Safety department), Geneva, Switzerland.

Abstract:

Health care-associated infections (HAI) are one of the most common adverse events in care delivery and are often caused by antibiotic resistant pathogens; both HAI endemic burden and the occurrence of nosocomial epidemics are a major public health problem and antimicrobial resistance (AMR) is one of the biggest threats to global health today. HAIs are avoidable and can be prevented by strong infection prevention and control (IPC) programmes and implementation strategies. In 2015, WHO reported that out of 133 countries assessed only 41% had a national IPC programme in place. To support countries in their efforts to prevent current and future threats, strengthen health service resilience and combat AMR through strong national action plans, WHO recently developed new recommendations on the core components of effective IPC programmes at the national and facility level. These new WHO guidelines are the result of evaluation of the best available scientific evidence, combined with knowledge from international experts, and wisdom and lessons learned from country experiences. They cover eight areas of IPC and include 11 recommendations and three best practice statements. Some innovative recommendations are included such as the identification of multimodal strategies as the most effective approach to improve practices and reduce HAI and AMR or the recognition of adequate bed occupancy and health care worker staffing levels as critical factors to reduce the risk of HAI and AMR spread. All countries should assess where they stand regarding the implementation of the WHO IPC core components and engage in improvement plans and local adaptations.

Keywords: Health care-associated infections, antimicrobial resistance, infection prevention and control

Speaker Information:

Benedetta Allegranzi, MD, DTM&H, is a specialist in infectious diseases, tropical medicine, IPC and hospital epidemiology. She currently works at WHO HQ (Service Delivery and Safety department), as the coordinator and technical lead of the IPC Global Unit. She is professor of infectious diseases in the official Italian professorship list and serves as adjunct professor at the Institute of Global Health, Faculty of Medicine, University of Geneva, Switzerland. She is the author or co-author of more than 150 scientific publications, and sixteen book chapters.

A 30-year Sustained National IPC (NIPC) Programme in Chile

Fernando Otaiza, MD, MSc, Ministry of Health (MOH), Chief of the National Infection Prevention and Control Programme, Chile

Abstract:

The National IPC program began as a response to outbreaks widely covered in the press. The programme is directed by the MOH and has four main areas: surveillance, training, guidelines and monitoring. The implementation used a multimodal strategy since the beginning. (1) First national action was to gather data to make HAIs visible. A basic surveillance system was established, that evolved adding active surveillance and later a set of indicators for different types of patients/infections. Currently hospitals report data to the MOH monthly using a computer program. (2) Training started with IPC nurses appointed to 16 of the 85 of the larger hospitals. Subsequently, other groups were trained in order to support the local programs such as medical directors, administrators, chiefs of clinical departments. Scientific Societies were involved in a national steering committee. Currently, continuous training involves all healthcare workers, with special focus on 171 professionals of the local programs and other leaders. (3) The MOH published a set of evidence-based guidelines and regulations on technical matters such as sterilization, safety of clinical procedures/devices, standard precautions/isolation and strategies to control AMR, amongst others. (4) Soon after starting, the MOH established a system to monitor the compliance of hospitals with the guidelines and regulations. Trained professionals perform the evaluations that include immediate feedback of the findings to hospitals and to the MOH in order to identify areas that need support or interventions at a national scale. Infection rates have decreased steadily in this period in all sites.

The successful NIPC programme has permanent leadership of the MOH, with trained professionals, problem solving according to data obtained through surveillance, use of evidence-based guidelines and monitoring of the performance.

Keywords: national program, infection control, leadership, surveillance, multimodal

Speaker Information:

Epidemiologist. Directs the National Program for Infection Control (NPIC) in Chile since 1983 with responsibility to develop surveillance of infections, guidelines for prevention of HAIs; outbreak investigation; train IPC staff; evaluation of programs. Coordinates nationally with activities such as Public Health emergencies, antimicrobial resistance and patient safety. Support international activities (PAHO/WHO) on response to epidemics, training and evaluation of IPC programs. Member of the WHO´s emergency committees on IPC matters for the influenza pandemic, Ebola and WHO's STAG on AMR.

Strengthening IPC Practices in a Low Resource Setting

Catherine Thomas Cooper, Dr., Ministry of Health, Assistant Minister for Curative Services, Liberia

Abstract:

The Ebola virus outbreak in West African highlighted weaknesses in the health systems of the three affected countries. It particularly revealed a gap in the area of infection prevention and control (IPC) and in quality health service delivery in the Liberian health sector. By the end of the outbreak in 2015, there were 10, 885 EVD cases. There were 4,841 cumulative deaths of which 192 were health workers. The Ministry of Health in an effort to address the gaps highlighted during the outbreak, introduced several IPC strategies and approaches. A Quality Management Unit was established with oversight for IPC at the end of the outbreak. The strategies addressed IPC training, supervision, supply chain, risk assessment of exposed health worker, mentorship and infrastructural improvement. This presentation reviews strategies used during the recovery period in the health system to ensure that the implementation of IPC practices continued to be sustained. Through a regional approach, the ministry had worked with WHO to develop a set of indicators for IPC and WASH that focuses on IPC practices. The target population includes 770 health facilities in the public and private sector. The monitoring tool used had eleven (11) indicators. The process begun in July 2016 and the analysis being reported is from September to December 2016.

The results over the period showed a national average IPC compliance of 41%. The best performing indicators were that of a dedicated IPC/WASH person (71%) and water supply availability (70%). The indicators performing poorly were that of water storage – safe use of water tanks (2%), occupational health – health worker exposure (4%) and in-service training (12%).

The ministry believes that keeping a visible focus on the IPC practices through a monitoring mechanism will ensure that IPC continues to be a prioritized. In a low resource setting a system of tracking progress can assist the health sector in setting its priorities and aligning its resources to those defined priorities. This monitoring system has contributed significantly to ensuring that patient safety and quality improvement continues to be a priority in the Liberia health system.

Keywords: Safety; monitoring; prioritization

Speaker Information:

I am Dr. Catherine Thomas Cooper a medical doctor who works in Monrovia, Liberia. I have had fifteen years of experience working as a medical doctor. I have six years of clinical practice in paediatric medicine. Additionally I have nine years' experience in public health with particular skill in programmatic management, disease control and 4 years' experience in infection prevention and control. I am employed with the Ministry of Health of Liberia. I have worked as the Program Manager, National Leprosy& TB Control Program (2008-2014);Master trainer IPC, Ebola task force (2014-2015); Chair person, Infection prevention and control task force, Ebola Response(2014-2015) and Director, Quality Management Unit, Ministry of Health (2015-2016): Assistant Minister for Curative Services, Ministry of Health (2016). I have skills and experience from the Ebola epidemic in Liberia. Post –Ebola I have worked on developing standards for patient safety, developing monitoring tools for IPC and introduced quality improvement projects at hospitals in the country.

How to Measure the Degree of Implementation? Establishment of Surveillance Systems, External Assessments vs Self-assessment

Julie Storr, World Health Organization, Consultant IPC & Quality UHC, UK

Abstract:

Infection prevention and control (IPC) is a central element of health care quality and safety. Absence of IPC has been shown to contribute to causing harm to patients and health care workers as well as catastrophic shocks to health systems in both high and low income settings. IPC therefore plays an important role in efforts to improve quality, contributes to the attainment of the sustainable development goals and is a core capacity for countries to attain in meeting the international health regulations. In November 2016 WHO issued its first guidelines on what comprises the core components of IPC programmes at the national and acute health care facility level. The target audience of the guidelines is manifold, however at the national level the recommendations are of particular relevance to policy-makers responsible for IPC, antimicrobial resistance (AMR) and quality and safety as well as accreditation and regulatory bodies.

Effective IPC minimizes harm to patients, reduces health care-associated infection, improves quality and therefore is a fundamental part of patient safety. Measurement, and its associated challenges, spans many of the guideline recommendations and is key to demonstrate their impact. This session will review the current status of national and international IPC measurement with regards to implementation of core IPC recommendations. The focus will be on the role of measurement and monitoring in the context of the implementation of the core components Guidelines, how existing data can be leveraged to accelerate improvements in IPC and patient safety across all countries, and how new assessment frameworks are being developed to address current measurement gaps.

Keywords: measurement; assessment; infection prevention

Speaker Information:

Julie Storr has over a decade of experience working for WHO on the development, implementation and evaluation of global improvement programmes in the field of patient safety, quality and infection prevention and control, with a focus on behaviour change. Her current work spans two WHO units – quality Universal Health Coverage and Global Infection Prevention and Control (IPC). Her technical and leadership expertise was called on to support WHO's Ebola response and recovery efforts in 2014/15, with a focus on national IPC policy development in Sierra Leone. She lead on the development of the recently published evidence based WHO Guidelines on the Core Components of Infection Prevention and Control Programmes at the National and Acute Health Care Facility Level. She was previously President of the Infection Prevention Society of the UK and Ireland, Assistant Director at the English National Patient Safety Agency and Director of the seminal cleanyourhands campaign. Julie has authored a book (Perspectives and Perceptions of IPC – highly commended at the 2016 BMA Medical Book Awards), published widely in the academic literature and is peer reviewer of a range of academic journals including Implementation Science, and on the international advisory board of the Journal of Infection Prevention. She is currently studying for a doctorate in public health (health care leadership and management) at Johns Hopkins Bloomberg School of Public Health, Baltimore.

The Special Problem of Sepsis: How to Prevent and Recognize it

Konrad Reinhart, Prof., MD ML, Jena University Hospital, Chair Global Sepsis Alliance, Germany

Abstract:

Sepsis as a syndromic response to infection and the final common pathway to death from most infectious diseases. Sepsis continues to cause every year more than six million deaths worldwide. The majority of sepsis deaths are community acquired. Sepsis has a unique and time-critical clinical course which in the early stages is highly amenable to treatment through early diagnosis and timely and appropriate clinical management. Infections which may lead to sepsis can often be prevented through appropriate hand hygiene, access to vaccination programmes, access to improved sanitation and water availability and other infection prevention and control best practices. Its ill effects in terms of mortality and long term morbidity can be mitigated through early diagnosis and appropriate and timely clinical management. This makes sepsis the number one cause of preventable deaths. Therefore, the WHA EB recommends to the 70th World Health Assembly the adoption of a resolution on sepsis that urges member staates to develop training for all health professionals on infection prevention and patient safety and the importance of recognizing sepsis as a preventable and time-critical condition with urgent therapeutic need and of communicating with patients, relatives and other parties using the term “sepsis” in order to enhance public awareness; and requests the WHO Director-General: (1) to draw attention to the public health impact of sepsis and identifying successful approaches for integrating the timely diagnosis and management of sepsis into existing health systems, by the end of 2018; (2) to support Member States as appropriate, to define standards and establish the necessary guidelines, infrastructures, laboratory capacity, strategies and tools for reducing the incidence of, mortality from and long-term complications of sepsis. The adoption of this resolution by the 70th WHA GA means a major contribution to improvements in patient safety.

Keywords: Sepsis, prevention, early diagnosis, patient safety

Speaker Information:

K. Reinhart is chairman of the Global Sepsis Alliance and the initiator of World Sepsis Day. He is a member of the International Sepsis Forum. In Germany he is member of the German National Academy of Science Leopoldina and Chairman of the Sepsis-Foundation. He was Founding President of the German Sepsis Society and its president from 2001- 2009. As speaker of the German research network SepNet he initiated landmark studies on the efficacy and safety of therapeutic approaches and on the epidemiology of sepsis in Germany. He was initiator of the Center for Sepsis Control & Care (CSCC) at Jena University Hospital. His publicly funded research is focused on quality improvement of sepsis management and long term sequelae of sepsis.

A Nationwide System for Adverse Events Reporting, Accessible to Healthcare Professionals and Patients alike

Christian Brun-Buisson, Prof. Dr., Ministerial delegate on antimicrobial resistance, Ministry of Health, France

Abstract:

Transparent reporting of serious adverse events (SAE) is a prerequisite for analysis of such events and identification of corrective measures and effective implementation of such measures. With regard to healthcare associated infectious events, France had first adopted a nationwide system of mandatory reporting, based on a limited set of infectious complications or events, and based on reporting by infection control professionals in healthcare institutions. Together with the development of the National Patient Safety Program, one pillar of which is "to improve reporting and management of healthcare-associated adverse events", as well as with the extension of the infection control program outside of healthcare institutions to encompass hospital, long-term care as well ambulatory care, a new web-based reporting system is being made available to all, including public, patients and healthcare professionals within acute or long-term stay institutions. The system directs the SAE report to regional subsidiaries and is backed up by regional support teams for each category of SAE to help institutions carry out the root cause analysis for each specific SAE, and check within a two-step process that appropriate corrective measures within a quality improvement program following the plan-do-study-act cycle have been taken. Regional support structures are thus accountable for the appropriate management of SAE. This web-based system is expected to broaden the scope of SAE reporting, allowing any event considered as serious to be reported, and will contribute to foster the development of a quality culture, based on patients' experience and needs. The system is also expected to allow reviewing experiences at the regional and national level by the national Authority for Health to help sharing best practices and knowledge.

Keywords: adverse events, reporting, web-based, regional support

Speaker Information:

Dr Brun-Buisson was trained in Intensive Care and microbiology, was appointed Professor at Université Paris-Est Créteil (UPEC), where he was head of the intensive care unit and of the infection control unit at university hospital Henri Mondor. He has chaired the advisory board for the national program for prevention of healthcare-associated infections at the ministry of health since 2005, and has been appointed ministerial delegate on antimicrobial resistance in Feb. 2016. He has authored or co-authored more than 400 papers, mostly related to sepsis and severe infections, healthcare-associated infections and antimicrobial resistance.

Economic Data and the Control of Healthcare Associated Infection

Nicholas Graves, Prof. Dr., QUT, Professor of Health Economics, Australia

Abstract:

This session is about how economics can inform decisions regarding competing infection prevention activities. Funding will always be insufficient to support every risk reducing strategy for every patient, and so choices have to be made about how to allocate scarce resources. I will include data about the cost-effectiveness of programmes to prevent infections of the blood stream, total hip replacements and some information on the cost-effectiveness of initiatives to improve hand hygiene in hospitals. The talk will represent the perspective of a rational health planner, working for the interests of the populations they serve. The expected outcome is improved understanding of how economic methods and data can be used to structure decision making for those in charge of infection prevention programmes. The future directions are that rational and cost-effective infection control becomes routine on health services. Better policy for infection prevention will optimize value from scarce resources and deliver maximum health gains for patients.

Keywords: cost-effectiveness; infection control; patient safety

Speaker Information:

Nicholas Graves did his PhD at LSH&TM on the UK Burden of HAI project in the 1990s. He is now a NHMRC senior research fellow and is developing health services research in Queensland with nationally competitive grants and by managing the Australian Centre for Health Services Innovation (AusHSI). He is motivated by research that improves health services. He has published in good journals like JAMA, BMJ, AIDS, Lancet Infectious Diseases, Emerging Infectious Diseases, Clinical Infections Diseases and Health Economics. He has received $25M in research funding since 2004 mostly from international and national competitive schemes.

The Development of a European Surveillance System for HAIs

Carl Suetens, ECDC, Senior Expert, Sweden

Abstract:

Collecting data on healthcare-associated infections (HAIs) from 30 different EU/EEA countries which can be used to make meaningful risk-adjusted comparisons requires standardisation of methods. Taking the ECDC point prevalence survey of HAIs and antimicrobial use in acute care hospitals (ECDC PPS) as an example, the process of building such a common international protocol is analysed. Steps in building a common system are: 1) review of literature and analysis of existing protocols (and demonstrate methodological differences); 2) obtain agreement by country representatives during meetings and teleconferences; 3) development of data collection tools (protocol, forms and software); 4) perform additional studies to provide scientific evidence when needed; 5) test the feasibility of the protocol and adapt it accordingly; 6) develop training materials and provide training for trainers. Agreement on main aspects such as objectives and case definitions were reached by consensus among experts, while for agreement on individual variables voting was often used as a decision tool. The protocol for the first ECDC PPS in 2011–2012 was established during 8 meetings from 2009 to 2011. From 2013 to 2015, 6 more meetings were held to discuss adaptations, new variables and indicators for the 2nd ECDC PPS in 2016-2017. In total, 229 experts of 30 EU/EEA Member States, EU enlargement and EU neighbourhood policy countries and international organisations and projects participated in the process.

Keywords: healthcare-associated infections, surveillance, Europe, ECDC, point prevalence survey

Speaker Information:

Senior Expert HAIs at ECDC, coordinator of ECDC's HAI-Net network since 2008, with following activities: surveillance of surgical site infections and HAIs in intensive care units, point prevalence surveys of HAIs and antimicrobial use in acute care hospitals and long-term care facilities, surveillance of Clostridium difficile infections and support to HAI prevention and control training. Before 2008: Head of HAI surveillance Belgium, WP leader in Improving Patient Safety in Europe project.

Hand Rub Consumption has almost doubled in 132 German Hospitals over a Period of 9 years

Petra Gastmeier, Prof. Dr., Charité – University Medicine, Institute of Hygiene, Germany

Abstract:

In January 2008 the German national hand hygiene campaign Aktion Saubere Hände (ASH) was launched following the World Health Organization's (WHO) call for global action to prevent HAIs and to improve patient safety. It is one of the longest continuously running hand hygiene campaigns on the national level. ASH sets out to realize a strategy of multiple interventions within the framework of WHO's Clean Care is Safer Care program to improve hand hygiene adherence in health care settings and to make it an integral part of hospital culture.

One substantial element of the German approach was to install a surveillance tool for the measurement of alcohol-based hand rub consumption (AHC) at the level of wards within the national surveillance system for HAI (KISS, Krankenhaus Infections Surveillance System). Hospitals participating in ASH transmit their AHC data by using a module named HAND-KISS. 1062 hospitals use the tool for internal quality management – that's more than half of all German hospitals.

Annual surveillance data (2007-2015), collected continuously in 132 German hospitals, was evaluated for development of alcohol-based hand rub consumption (AHC) as a surrogate parameter for hand disinfection adherence. Overall median increase in AHC was 94%. Increase over 9 years was significant in all units and quartiles of AHC at baseline.

To summarize, AHC monitoring is a simple and resource-efficient way to estimate the frequency of HD activities continuously and over time.

Keywords: Hand hygiene, surveillance, national campaign>

Speaker Information:

Petra Gastmeier is head of the Institute of Hygiene and Environmental Medicine, Charité – University Medicine Berlin. She is an expert in surveillance of nosocomial infections and antimicrobial resistance. She is coordinating the work of the German Nosocomial Infection Surveillance System (called KISS) with data from more than 1400 German hospitals. She is also responsible for the current German national hand hygiene campaign with more than 1000 hospitals participating.

Sepsis- the Hidden Global Healthcare Disaster

Ron Daniels, Dr., UK Sepsis trust, CEO, Global Sepsis Alliance, Clinical Adviser (Sepsis) to NHS England, UK

Abstract:
Sepsis is responsible for at least 44,000 deaths annually in the UK and a similar number in Germany, and accounts for 30-50% of episodes of inpatient deterioration. Globally, it accounts for an estimated 6-8 million deaths of whom many are in neonates and infants. Despite internationally recognized guidelines being endorsed by relevant professional bodies, standards of care are achieved in fewer than 20% of cases even in developed countries.

Evidence in support of basic elements of care- antibiotics and fluid challenges- suggests that they are more effective and their delivery more time critical than interventions in acute coronary syndromes. This session will explore potential conflict with strategies to ensure antimicrobial stewardship and preservation, and underline the commonality of messages. The roles of acute hospitals, the community, primary care and the prehospital environment will be explored to aid understanding and planning of a system-wide response. The session will also outline national and global strategies to embed sepsis as a clinical priority for health systems, discuss the new international consensus definitions of sepsis released in February 2016 and discuss the challenges they present. It will outline the implications of the recently published NICE (UK) Clinical Guideline in the context of these definitions, and importantly highlight that improving outcomes from sepsis demands that we engage with our public.

Keywords: Sepsis, Deaths, Definitions, Systems, Improvement

Speaker Information:
Dr Ron Daniels is a full time NHS Consultant in Intensive Care and Anaesthesia, based in Birmingham. He's also Chief Executive of registered charities, the UK Sepsis Trust and the Global Sepsis Alliance (GSA). In 2016 he was awarded the British Empire Medal for services to patients.

Ron and his team developed both the 'Sepsis Six' care bundle, now in use in 22 countries, and the clinical concept of 'Red Flag Sepsis'. He has lobbied the United Kingdom Government, together with devolved governments in Scotland and Wales, over several years culminating in an announcement by the Secretary of State for Health of a resourced suite of measures to transform sepsis care across the UK. He has been instrumental in bringing World Sepsis Day and the GSA Chairman's concept of the World Sepsis Declaration to fruition and will co-present a resolution on sepsis to the WHO in Geneva in May.

The Role of Patient Empowerment on Hand Hygiene Compliance

Maryanne McGuckin, Dr., FSHEA, McGuckin Methods International, President, USA

Abstract:

The concept of Patient Empowerment in Infection Prevention began in 1982 but healthcare faculties did not embrace this concept. Beginning in 1999 with the IOM report, NPSGs, CDC and WHO Guidelines this changed, making empowerment a component of many safety programs including hand hygiene compliance. Multi-modal hand hygiene programs that include patient empowerment are promoted as a necessary component of hand hygiene compliance. However, the question still remains, do we have enough information to determine if, and under what conditions, patients will be able to play an immediate role in healthcare workers' hand hygiene behavior? Several studies show that, in principle, patients are willing to be empowered. However, the actual number of patients that practice empowerment for hand hygiene range from 5% to 80%. Our recent studies have shown that this range may in fact be due to the fact that patients believe hand hygiene compliance is not a problem and therefore there is no need to be empowered to ask. The actual performance of patient empowerment can be increased when a healthcare worker gives a patient explicit permission. Therefore, we must develop programs that empower healthcare workers, patients and consumers so they become comfortable in their roles.

In summary, we have enough evidence to move patient empowerment from "feasible" to necessary only if we stop looking for reasons why patient empowerment does not work and build on programs that have been proven.

Keywords: Patient Empowerment, Hand Hygiene, Compliance

Speaker Information:

Dr. McGuckin is an internationally renowned advocate for healthcare quality, patient safety, and patient advocacy. She is the author and developer of Partners In Your Care, an empowerment method for increasing hand hygiene compliance. Dr. McGuckin's work is re-presented in over 100 peer-reviewed abstracts, journal articles, and scientific conference lectureships. Her recent book, *The Patient Sur-vival Guide 8 Simple Solutions to Prevent Hospital and Healthcare-Associated Infections*, empowers consumers before they become patients. Dr. McGuckin was a member of the faculty and staff of University of Pennsylvania, USA.

Workshop 5: Increased Safety of Diagnostics and Treatment - Checklists and Other Tools

The key point of emphasis of this workshop will be the topic of safety culture. In this context, examples - as they have been included e.g. in the brochure on best practices which will be published in preparation of the summit - will be used to show in a practice-oriented manner how safe action can be applied in medical care. In addition to international models of success (.e.g. High 5s) and their adaptation to national health care systems, the implementation of checklists, the dissemination of recommendations for action and patients' information as well as the integration of the topic of patient safety in curricula of medical education could be good examples.

In diesem Workshop soll das Thema Sicherheitskultur im Mittelpunkt stehen. Dabei soll praxisorientiert anhand von Beispielen - wie sie z.B. in der zum Summit erscheinenden Best-Practice-Broschüre enthalten sind - gezeigt werden, wie sich ein sicheres Handeln in der medizinischen Versorgung umsetzen lässt. Neben internationalen Erfolgsmodellen (z.B. High 5s) und deren Anpassung an nationale Versorgungssysteme könnten die Umsetzung von Checklisten, die Verbreitung von Handlungsempfehlungen und Patienteninformationen sowie die Implementierung des Themas Patientensicherheit in den Lehrplänen und Curricula in der medizinischen Ausbildung gute Beispiele sein.

Chair: Prof. Dr. Matthias Rothmund

Philipps University Marburg, Professor of Surgery emeritus, Germany

Chair Information:

I completed Medical School at Johannes Gutenberg University in Mainz/Germany in 1968 and had my Surgical Education at the University Hospital there until 1975. After that I became Assistant Professor and later Associate Professor at the same institution. In 1987 I was called to the Chair of Dept. of Surgery at Philipps University Hospital in Marburg. I held this position until 2008. Then I served as Dean of the Medical School at the same University until 2013.

When I served as President of the German Surgical Association in 2004/2005 patient safety was the main topic at the Annual Congress and hereby the issue was presented to the public in Germany for the first time. In 2005 the German Task Force on Patient Safety was founded, where I served as a founding member of the steering committee for several years. In 2015 I published a paper on the current state of use of patient safety tools and informations in German surgery 10 years after these were installed in German hospitals.

Safety Culture Development as a Core Leadership Responsibility

Tanja Manser, Prof. Dr., University Hospital Bonn, Director Institute for Patient Safety / Professor for Patient Safety, Germany

Abstract:

The continuous development of safety culture in healthcare organizations is a key challenge healthcare leaders are facing when aiming to maintain and improve patient safety. One the one hand, safety culture is a prerequisite for the sustainable implementation of patient safety practices at various levels of the healthcare system. On the other hand, safety culture is also constantly evolving as it "emerges through a social process, where staff attach meaning to the policy and practice they experience and the behaviours they observe" (Health Foundation, 2013). Current models of safety culture development highlight the crucial role of leadership throughout the organization in leading and facilitating culture change and define three processes through which tools for patient safety improvement can impact on this change: enabling, enacting and elaborating (Singer and Vogus, 2013). Understanding these processes can contribute to more targeted and thus more effective strategies a) for using these tools in healthcare organizations, b) for involving leaders and frontline staff in their implementation and c) for evaluating their effects taking into consideration their role as part of a larger change process to develop safety culture.

Keywords: leadership, organizational learning, patient safety improvement, safety culture

Speaker Information:

Tanja Manser is Full Professor for Patient Safety and Director of the Institute for Patient Safety at the University Hospital Bonn, Germany. She is a leading expert in Europe on team performance in healthcare and its relationship to patient safety. Her research focuses on teamwork in acute care settings, quality and safety of patient hand-offs, clinical risk management, safety climate in healthcare and implementation of patient safety practices. She also holds appointments as Adjunct Professor for Patient Safety at the University of Stavanger, Norway, and as honorary Senior Lecturer at ETH Zurich, Switzerland.

A Practical Approach: Implementation of a Safe Surgery Checklist

Patrick Fränkel, Dr., MD, University Hospital RWTH Aachen, Head of Clinical Quality and Risk Management, Germany

Abstract:

As a participant in the WHO High Fives project the University Hospital RWTH Aachen first started with the implementation of a safe surgery checklist in 2010. In terms of the continual improvement process an efficiency analysis was conducted after implementation. Here, potential for improvement was identified resulting in a revision of the checklist that mainly concerned the more distinct assignment of responsibilities. In addition it became apparent that the safe surgery checklist does not only affect patient safety, but also contributes to organizational development.

Keywords: Safe Surgery, Checklist, Implementation

Speaker Information:

Born in 1966; attended medical school in Düsseldorf, Nantes (France), Aachen; specialized in anesthesiology and intensive care medicine; perennial experience in consultancy and hospital administration; cooperation manager in health and community care (MA); quality manager

Lessons from the Oil and Gas Industry to Improve Patient Safety

Abdulelah Alhawsawi, Dr., Ministry of Health, Director of the Saudi Patient Safety Center, Saudi Arabia

Abstract:

High reliability organizations have reduced the number of errors in their operations by investing in safety culture and continuous improvements. Health care has adopted several practices from non-health care settings, such as use of checklists from the aviation industry. The Kingdom of Saudi Arabia's Ministry of Health invited WHO's Patient Safety and Quality Improvement Unit and a few international experts to visit the Saudi Aramco, the national oil and gas company. The objective of the mission was to gain insight into the safety principles and practices in non-healthcare settings and assess their applicability to health care for improving patient safety globally. The two-day visit to Saudi Aramco involved direct observations and evaluations of safety practices. A number of parallels were drawn with health care safety based on these observations.

Lesson 1 – Institutional Commitment to Safety Culture: Safety culture is a part of the corporate culture. Every employee is well versed with the values of the company and what their roles are to keep a safe workplace. Clear supervisory roles and accountability channels were maintained from the senior management to the frontline workers. A significant spill over effect of safety training is noted in the community, shown by reduced rates of motor vehicle accidents in and around the Saudi Aramco communities.

Lesson 2 – Capturing near misses to improve systems and reduce human errors: Strong reporting and learning systems are in place to capture not only safety incidents but also near misses. As a result, improvement initiatives have been undertaken to improve the safety of each process. Health care organizations are usually hierarchical institutions, and often lack a strong safety culture to facilitate the reporting of errors and near-misses. There is a strong need to enforce and empower health care professionals to report in blame-free environment.

Keywords: High Reliability, Near-Miss, Safety Culture

Speaker Information:

Dr. Alhawsawi is one of Saudi Arabia's healthcare quality leaders and advocates. He is currently the Patient Safety Advisor to the Saudi MOH. Additionally, Dr. Alhawsawi is an accomplished surgeon, serving as an Assistant Professor at the Faculty of Medicine, King Abdulaziz University, Jeddah, Saudi Arabia. Dr. Alhawsawi holds a bachelor's degree in Medicine from King Abdulaziz Universit. Dual board certified in transplant and hepatobiliary surgery, he completed his training in Mount Sinai School of Medicine, New York. He is a member of numerous medical societies and national quality committees. Dr. Alhawsawi's mission in life is to contribute to the advancement of healthcare in the Kingdom; he divides his time between patient care, teaching and research in healthcare quality.

Patient Safety Audits based on data provided by Liability Insurers

Peter Gausmann, Dr., GRB Gesellschaft für Risiko-Beratung, Geschäftsführer, Germany

Abstract:

A Patient Safety Audit (PSA) in a clinical environment is a systematic and independent investigation of structures and processes and their results, with which the application of specific measures for avoiding adverse events in diagnostics, therapy and care is assessed. Such audits can be carried out anywhere in a hospital or in a specialist department or for specific medical care processes (e.g. in the operating room or in obstetrics) or in trans-sectoral healthcare structures. In addition to the existence of safety-relevant processes and willingness for change by the audited organization, the voluntary nature of participation and, in particular, the methods along with social skills of the auditors are prerequisite for PSAs. By virtue of their experience, the auditors' role is, in particular, to create awareness for the problems and to uncover and highlight „blind spots" among the relevant therapeutical teams. The concept presented here is based on the analysis of real-life liability cases associated with the healthcare and nursing sector which were incurred by about 1,000 hospitals throughout Germany over a period of 20 years. Far more than 100,000 casuistics have been analyzed where a causal link between (medical) error and damage to the patient could be established. This is the basis of an examination procedure in the context of which prevention measures, that are potentially suitable to prevent similar damage, are monitored and analyzed during clinical processes in the audited areas. The audit's main objective is the development of a prevention profile which may have a positive influence on the insurability of high-performance medicine and nursing. Consistent with the basis of the PSA, namely to derive findings from real-life damage data, the following areas are assessed: treatment and care, diagnostics and treatment planning, organization of care processes, patient information and consent form, and documentation and team communication.

It is possible to calculate a patient safety index by weighting individual prevention measures in relation to probability of occurrence, the scope of damage and the degree of implementation. The direct relevance to real-life damage and claims not only facilitates awareness-raising among the therapeutical team but also the implementation of reorganization processes. Execution of a Patient Safety Audit and presentation of audit findings are also suitable for the public image of a hospital in terms of patient safety marketing. Conclusion: Patient Safety Audits that are based on real-life damage and claims raise awareness among therapeutical teams. The findings of audits create ideal conditions for the insurance coverage of hospitals. The level of patient safety is measurable. Patient Safety Audits enhance the image of a hospital.

Keywords: Patient Safety Audits PSA, Errors in treatment and nursing care, Patient Safety Index, Liability Insurers, Patient Safety Marketing

Speaker Information:

Managing Director of GRB Gesellschaft für Risiko-Beratung, Honorary professor of the Danube University Krems, Consultant, author and lecturer on the topics of patient safety and clinical risk management , Member of the board of the platform Patient Safety in Austria and Member of the German-Chinese Society of Medicine

Involving Patients in the Provision of Safe Care

Katja Stahl, Dr., Picker Institut Deutschland gGmbH, Director Research & Development, Germany

Abstract:

The debate on patient involvement in the provision of safe care processes is still controversial. However, there is growing evidence that patients want to be involved in their own care in general as well as in specific safety aspects. Their feedback is reliable and provides important information that cannot be gathered elsewhere. An important prerequisite for successful patient participation is the support by health professionals since patients are anxious not to disrupt the provider-patient-relationship. Feedback from over 90.000 inpatients from 142 German hospitals show that communication with their carers during their hospital stay and around discharge as well as coordination of processes are the main areas of concern from the patients' perspective.

Keywords: patient involvement, patient safety, communication

Speaker Information:

Dr. rer. medic. Katja Stahl is director of Research & Development at the Picker Institute Germany gGmbH. Her research focus is in assessing and improving the quality and safety of care from the patient and staff perspective. Her scientific background is in midwifery and nursing science where she holds a Master degree from the Universities of Bremen, Germany and Aberdeen, Scotland, and a PhD in Medical Sciences from the University of Osnabrück, Germany.

Patient Involvement at the Organization Level of Health Care Institutions

Solvejg Kristensen, MHsc, PhD, Aalborg University Hospital – Psychiatry & Department of Clinical Medicine, Aalborg University, PROM-project leader, Denmark

Abstract:

Currently most information about patient safety and quality of care is provided by health care professionals, and it seems time to listen to patients - involve patients - in organisational improvement to a new degree, and act out “Nothing about us without us”.

Across the globe there is a growing interest in involving patients in actions and interventions to promote a clinical culture, which supports the delivery of high quality, safe care to patients. New attitudes are facilitating a more equal balance of power, where patients can increasingly expect to be involved in providing data systematically, decision-making and treatment planning for their own health, and organisation level activities aiming for safer quality of care.

The field of patient involvement is a new scientific area; open questions remains to the pros and cons, but experience as well as emerging evidence show benefits. But, many health care organisations struggle to substantiate patient involvement in daily practice, and the question; how are patients best involved in organisational level initiatives aiming for safer care? is more evident than ever, and will be treated in this presentation.

Initiatives such as: patient safety leadership walk rounds, using individual patients and patient peer boards as top management advisors and cooperative partners in improvement initiatives, and using patient reported data for safety improvements, will be presented.

Patient safety initiatives building upon patient involvement can help bridge perception gaps between patients and health care workers, and between health care workers and clinical leaders, promote a safe culture and support safer care. At the organisational level involving patients can help leaders create a safer culture and contribute to better care. There is no doubt that patient involvement under the right conditions is a win-win situation for organisational development of patient safety.

Keywords: Patient Safety Walk Rounds; Patient Peer Boards; Patient Reported Data

Speaker Information:

Solvejg Kristensen holds is a Master of Health Science and a PhD within patient safety culture. Since 2003, she has worked with patient safety for Aarhus University Hospital, the Danish Clinical Registries, the Danish Society for Patient Safety, as well as led projects for the European Society for Quality in Healthcare. She is currently employed as a project manager and researcher focusing on national level patient reported outcome measures within psychiatry. Solvejg Kristensen has extensive experience as a lecturer, supervisor and as speaker at scientific conferences. She has published research within patient safety, quality of care and child psychiatry.

Patient Safety – Involvement of Patients in Regulation and Governance in Germany

Cordula Mühr, MD, Patient Representative in the Federal Joint Committee (G-BA), Germany

Abstract:

A systems-based approach to patient safety requires action at all levels and by all participants. In addition to individual attention patients and advocacy groups that represent patient interests can make a significant contribution to patient safety on levels of regulations and governance. This gets even more important in order to ensure, that cost containment and budgets cuts do not undermine safety and quality of care. In this presentation different levels of patients' involvement in regulation and governance in the German healthcare-system are shown, with emphasis on the involvement in the Federal Joint Committee (G-BA). The G-BA is a public legal entity comprising the four leading umbrella organizations of the self-governing German healthcare system: the National Associations of Statutory Health Insurance Physicians and Dentists, the German Hospital Federation, and the Central Federal Association of Health Insurance Funds. In addition to these four pillar organizations, patient representatives also participate in all sessions; they are entitled to put topics on the agenda, but not to vote. Examples are given of how patient advocacy-groups are putting safety-topics on the agenda of the G-BA with the objective of establishing minimum standards, ensure health care providers to be open about the effectiveness, safety and patient-centeredness of care they provide, hold providers accountable and enable enforcement actions, if necessary.

Keywords: patient safety, patient involvement in different levels of German healthcare-system, Federal Joint Committee (G-BA)

Speaker Information:

Cordula Mühr, MD MSc.PH (without professional activity), since 2004 patient representative in the self-governing German healthcare system (on a voluntary basis). Spokesperson in the quality assurance subcommittee of the Federal Joint Committee (G-BA), Germany. Thematic priorities: quality assurance, patient safety, patient questionnaires as tool for quality assurance, infection prevention, methods assessment

Diagnostic Error: A New Frontier in Patient Safety

Victor J Dzau, MD, National Academy of Medicine, President, USA

Abstract:

Nearly 20 years ago, the US Institute of Medicine (IOM) (now renamed the National Academy of Medicine) released a landmark report, To Err is Human: Building a Safer Health System, which dramatically exposed the significant problem of medical errors in health care, spurring system wide efforts to improve patient safety and quality care. However, a critical element has largely been absent from the patient safety and quality movements – diagnostic error. Getting the right diagnosis is fundamental to the delivery of high-quality health care: a diagnosis explains a patient's health problem and it sets the stage for subsequent health care decisions. Diagnostic error – inaccurate and delayed diagnoses – persist throughout all settings of care and continue to harm an unacceptable number of patients, sometimes with devastating consequences. Medical record reviews reported that diagnostic errors account for 6 to 17 percent of hospital adverse events. 5 % U.S. adults seeking outpatient care each year experience a diagnostic error of which half leads to harm. Postmortem examination research spanning decades has shown that diagnostic error contribute to approximately 10 percent of patient deaths. Diagnostic errors are the leading type of paid medical malpractice claims. Diagnostic errors can be costly - unnecessary office and hospital visits, wrong treatments, unnecessary tests and procedures, readmissions and deteriorating health status.

To address the problem of diagnostic error, the IOM released a follow up report in 2015, Improving Diagnosis in Health Care. The report is a serious wake-up call that we still have long way to go to improve patient safety.. Urgent change is warranted to address this challenge. Improving diagnosis will require collaboration and a widespread commitment to change among health care professionals, health care organizations, patients and their families, researchers, and policy makers. Without a dedicated focus on improving diagnosis, diagnostic errors will likely worsen as the delivery of health care and the diagnostic process continue to increase in complexity.

Keywords: diagnostic error, health care delivery

Speaker Information:

Victor J Dzau, MD, is President of the US National Academy of Medicine. He is an internationally acclaimed leader and scientist whose work has improved health care in the United States and globally. Under his direction, the National Academy of Medicine advances research and improves health by providing objective, evidence-based guidance on critical issues. His foresight in translation of research into diagnostic methods, medicines, and creative solutions for human health issues is a great asset to the Academies and to the public at large. His own research laid the foundation for development of angiotensin-converting-enzyme (ACE) inhibitors, used globally to treat high blood pressure and congestive heart failure. He pioneered gene therapy for vascular disease and was the first to introduce DNA decoy molecules to block transcription as gene therapy in humans. Prior to becoming President of the National Academy of Medicine, Dr. Dzau served as Chancellor for Health Affairs and President & CEO of Duke University Medical Center. He has received numerous awards including the Max Delbruck Medal from Germany, the Gustav Nylin Medal from the Swedish Royal College of Medicine, the Polzer Prize from the European Academy of Sciences & Arts, the Ellis Island Medal of Honor, and the Distinguished Scientist Award of the American Heart Association.

Participation Promotes Culture!

Guenther Jonitz, Dr. med., Berlin Chamber of Physicians, President; Sonja Barth, Berlin Chamber of Physicians, Head of the Department of Health Policy, Germany

Abstract:
Patient Safety is a challenge and a chance: Preventing patients from adverse events within a complex system is the challenge. Promoting better and safer systems for health care is the chance. Key factors for patient safety are value (from the patient's point of view), participation and culture, all promoted by leadership.

The German strategy of implementation were:

- Leadership by professionals and leading institutions
- Positive framing: Bad issue but „glad news"!!
- Take action! (No more victims – help yourself AND your patients, personal benefit for health care professionals)
- Participation, honesty, appreciation, support, friendliness, cooperation, confidence
- Free access and share ware of know how and products/ materials (recommendations, scientific results, reports, informations...)

Example initiatives taking these key factors into account are the "German Coalition for Patient Safety" (founded in 2005), the „European Union Network for Patient Safety and Quality of Care" (PasQ Joint Action, finished in 2016) and the German initiative „Gesundheitsziele.de", working group for patient safety (since 2014). These examples show that political leadership (top-down-support), and the participation of all stakeholders in health care (bottom-up-development) are essential for promoting safety culture and patient safety.>

Keywords: leadership, participation, safety culture

Speaker Information:
Dr. med. Guenther Jonitz is born in Munich, Germany, on 19. June 1958. License to practice medicine in 1984, specialist for surgery in 1994. Since 1999 he is the President of the Berlin Chamber of Physicians and a member of the board of the German Medical Association (BÄK). At the German Medical Association he is the Chair of the quality assurance bodies and he represents the German Medical Association in the Board of Trustees of the Institute for Quality and Efficiency in Health Care (IQWiG) and of the Institute for Quality and Transparency in Health Care (IQTIG). He is founding member and formerly Chair of the German Coalition for Patient Safety (APS) as well as founding member of the German Network for Evidence Based Medicine (DNEbM). He is working as expert and advisor of the German Federal Ministry of Health (BMG) on questions relating to patient safety in international organizations (e.g. EU Commission). He is also the leader of the nation-wide German working group "Patient Safety" which started its work in October 2014. This working group is part of the national programme "Gesundheitsziele.de". In the year 2016 he was awarded with the Federal Cross of Merit (Bundesverdienstkreuz) for his achievements in the area of patient safety.

Workshop 6: Safety of Medication Therapy

The aim of this workshop is to consider safety when dealing with medicinal products with particular regard to demographic change. Especially where the elderly are concerned, medication errors and adverse drug events frequently occur. Therefore, preventive measures shall be discussed above all, as they may help to avoid medication errors among this group of patients, and also the subsequently resulting expenses in the future. WHO will present the 'Global Patient Safety Challenge - Medication Safety' which it plans to launch in the first half of 2017.

Ziel dieses Workshops soll sein, die Sicherheit im Umgang mit Arzneimitteln unter besonderer Berücksichtigung des demographischen Wandels zu betrachten. Insbesondere bei älteren Menschen kommt es häufig zu Medikationsfehlern und unerwünschten Arzneimittelereignissen. Daher sollen vor allem vorbeugende Maßnahmen diskutiert werden, durch welche Medikationsfehler auch bei dieser Patientengruppe und daraus resultierende Kosten in Zukunft vermieden werden können. Die WHO wird die im ersten Halbjahr 2017 startende "Global Patient Safety Challenge - Medication Safety" vorstellen.

Chair: Prof. Dr. Wolf-Dieter Ludwig

Chairman, Drug Commission of the German Medical Association (DCGMA), Head of Hematology, Oncology and Tumor Oncology, HELIOS Klinikum Berlin-Buch; Member of the Medicines Commissions of the German Medical Association, Germany

Chair Information:

Prof. Wolf-Dieter Ludwig is Chairman of the Board of the Drug Commission of the German Medical Association (DCGMA) and Head of the Dept. of Hematology, Oncology, Tumor Immunology and Palliative care at the HELIOS Clinic Berlin-Buch. Inspired by international initiatives and the 1st Congress for Patient Safety in Drug Therapy in 2005, the topic of safeguarding the medication process has entered the political discussion in Germany. Under the scientific management of DCGMA, four action plans for improving drug safety have already been developed. The financial amounts for the measures and research projects - provided by the Federal Ministry of Health (BMG) - illustrate the current activities to improve safeguarding the medication process. Prof. Ludwig is author and co-author of numerous scientific publications and book chapters. Since 2006 he is co- editor of the independent drug bulletin “Der Arzneimittelbrief”. Since 2013 he is Member of the Management Board of the European Medicines Agency (EMA) as representative of European doctors’ organisations.

Presentation:

The German Action Plan for Medication Safety

The German National Medication Plan

Martin Schulz, Prof., PhD, FFIP, FESCP, Chairman, Drug Commission of German Pharmacists (AMK), Berlin, Germany

Abstract:

It is essential that patients know what medication to take and how to administer it in order to ensure medication safety as well as to improve medication adherence. The German National Medication Plan (MP) is a printable document for the patient that clearly lists his/her complete medication (Rx and OTC) in a standardized format. It specifies the active ingredient, trade name, strength, dosage form, dosing regimen, application information, and the medical indication for each drug. Identified as a relevant patient safety indicator for Germany, the MP has been developed within the context of the Action Plans for Medication Safety of the Federal Ministry of Health. The content and template has been presented and discussed with stakeholders from all parts of the health care sector and eventually consented. The MP was enacted into law (§ 31a Social Law Book V) so that all insured persons who simultaneously use at least 3 prescribed medicines are entitled to receive a MP (first in paper, later-on electronically) as of 1 October 2016. Facilitating correct administration and avoiding medication errors are aiming to improve medication safety and effectiveness eventually. Recent studies showed, however, a high potential for discrepancies in the different patient records and evidence for a compromised patients' comprehensibility of the MP. Utilizing prescription, dispensing and claims data, performing a structured medication (brown bag) review, developing a consolidated MP between physicians and pharmacists and counselling as well as monitoring patients is considered a promising approach. This concept is currently applied in two Federal States involving more than 1,500 physicians and pharmacists in the project ARMIN (www.arzneimittelinititative.de).

Keywords: Medication safety, Medication plan, Medication schedule, Patients' understanding, Polymedication

Speaker Information:

Martin studied Pharmacy (1978-1983) and Medicine (1984-1986). After finishing his PhD, he specialized as a pharmacologist and in drug information. Since 2008, he is the Managing Director of the Department of Medicine at ABDA - Federal Union of German Associations of Pharmacists. In addition, he is Director Pharmacy of the German Institute for Drug Use Evaluation and since 2009 Chairman of the Drug Commission of German Pharmacists (AMK). He is an Adjunct Professor at Goethe-University Frankfurt and a Lecturer in Clinical Pharmacy at Freie Universitaet Berlin. Since it's inauguration in 2008, he is a member of the managing committee on the Action Plans for Medication Safety (AMTS) of the Federal Ministry of Health. He has published over 500 papers and presented over 400 talks.

Medication at Transitions in Care

Ciara Kirke, Clinical Lead, Medication Safety Programme, Health Service Executive Quality Improvement Division, Ireland

Abstract:

When patients move from one healthcare setting to another, discrepancies between the intended medication and the medication in use frequently occur. At each transition, the patient's complete and correct medication list needs to be determined, used to deliver the care required, and the updated list and reason for changes communicated to the patient and future providers. Achieving this represents a considerable challenge which many healthcare systems are not reliably meeting.

Evidence-based, cost-effective solutions are known. The most effective, pharmacy-led medication reconciliation on admission and discharge from hospital, requires investment in dedicated resources and delivers a return on this investment.

To comprehensively improve and ensure patient safety at transitions, we need:

- better information
  - patient-centred continuous medication record across transitions (paper / electronic),
  - patients who understand their medication,
  - better communication at transitions (aided by interoperable IT systems and/or forms),
- better processes
  - to ensure a best possible medication history is taken,
  - medication reconciliation takes place and
  - medication changes are reliably communicated,
- restructuring and investing in optimising medication processes, including reconciliation and
- to prioritise enhanced services for those at highest risk of medication-related harm.

Medication discrepancies affect nearly every patient who enters or leaves hospital. Isn't it time we stop this?

Keywords: Medication, reconciliation, transitions, patient safety

Speaker Information:

Ciara Kirke leads the Irish national medication safety programme with the HSE QID, reducing patient harm from medicines or their omission in collaboration with healthcare organisations. She led a university hospital medication safety programme for over 10 years and has promoted quality improvement and patient safety throughout her career as a pharmacist. She contributes to national, European and global patient safety with the EMA, IMSN and WHO.

Critical Success Factors for Medication Safety

Daniel Grandt, Prof. Dr., Drug Commission of the German Medical Association (AkdÄ), Germany

Abstract:

Patients still suffer harm from preventable adverse drug events. Prescribing errors are most relevant. Contributing factors are (1) missing information on patients, (2) not applying established knowledge on drugs, (3) failure-prone treatment processes. Medication safety requires:

(1) Mandatory coding systems for drugs, drug ingredients, drug dosing and lab test results: Interoperability needs these standards for information exchange, ideally as international standards.

(2) Drug treatment processes must be analyzed to detect uncontrolled risks and to redesign processes for resilience. Tools like Failure-Mode-and-Effect-Analysis should be used, allowing processes to be redesigned for resilience, so that errors that occur do not reach the patient.

(3) Risk-awareness and risk-attitude have to be improved: Like the value of a safety belt in a car cannot and should not be judged by one´s own (driving) experience, this is also true for the risks of inadequate drug therapy.

(3) A mandatory systematic yearly drug therapy review has to be implemented: The medication plan is necessary but not sufficient for medication safety. Patient factors can change over time, as can effectiveness and side-effects of drugs. Systematic drug therapy reviews are necessary to assure that therapy is adequate continuously.

(4) Measuring medication safety has to be part of routine quality control measures: Measuring medication safety is a precondition of continuously reducing risks and establishing resilience.

(5) Medication safety has to be established as a precondition of care: Preventable harm is more often due to competing goals that can only be reached by ignoring safety rules, than by individual failure. German law (SGB V) should explicitly state: the patient´s right on medication safety, the healthcare provider´s responsibility to guarantee medication safety, and the health insurance company's task to support both of them.

Keywords: Medication Safety, Medication errors, Preventable Adverse Drug events, Resilience

Speaker Information:

Daniel Grandt, MD, Medical Faculty University of Essen–Duisburg, Professor of Internal Medicine, Head of Department of Internal Medicine I, Klinikum Saarbruecken, Member of the Board of Directors of the Drug Commission of the German Medical Association, the International Medication Safety Network (IMSN), the WHO expert group "Research on Patient Safety " (World Alliance for Patient Safety), expert panel member and reviewer for the WHO "Small Research Grant Project", Chairman of the Working Group on Medication Safety of the German Association of Internal Medicine, President of the German Congresses on Medication safety 2005-2013, Founding member and CEO (2005-2007) of the German Coalition on Patient Safety.

New Forms of Risk Communication

Norbert Paeschke, Dr., Federal Institute for Drugs and Medical Devices, Head of Pharmacovigilance Department, Germany

Abstract:

The objective of risk communication is make information available for the safe use of drugs for health care professionals and patients. There are various tools available such as the traditional product information but also health authorities' websites, supported by access to underlying source data such as ADR-reports or other informative texts with a more general scope. A comparably new aspect of risk minimization activities in relation to risk communication is the provision so-called educational material aiming to provide additional information specifically designed to address important risks when using a particular drug, giving detailed information concerning precautionary measures and supervision of drug treatment. It is considered relevant to judge a drug's benefit-risk balance to be positive. There are different forms of educational material in use, such as videos, patient alert-card or checklists to be used in advance to start of drug treatment or in the context of its supervision. Not all of such materials are suitable to be provided with each package. A central repository is therefore considered a helpful and reliable source where such information can be found. Based on experience it is important to distinguish authorized educational material from other materials since confusion with advertising activities needs be avoided. Educational material is a form of risk communication which is considered an additional tool supporting risk minimization of drug use and thus improving patient safety.

Keywords: risk communication, educational material, risk minimization, benefit-risk balance

Speaker Information:

Norbert Paeschke was born in 1959 and passed his examination as physician in 1985 in Berlin. Thereafter, he joined the Pharmacovigilance department at BfArM (former BGA), where he became responsible head for the management of the ADR-database in 1997. Since 2013 he is head of the Pharmacovigilance Department at BfArM. He was or is still active in various international working groups, e.g. CIOMS V: „Current Challenges in Pharmacovigilance - Good Case Management and Reporting Practices" (1997-2001), EU-Topic Leader in the ICH-Expert Working Group E2D: "Post-Approval Safety Management - Definitions and Standards for Expedited Reporting" (2002-2003), deputee member in the Management Board of the „Uppsala Monitoring Centre" (UMC, 2003-2011). Since 2002 he is member of the "CIOMS-Working Group on Standardised MedDRA Queries (SMQs)", since 2007 also acting as member of the ICH-MedDRA Advisory Panel and of the MSSO's MedDRA Expert Panel.

Global Launch: Global Patient Safety Challenge -Medication Safety

Patient harm resulting from unsafe medication practices and medication errors is a universal issue. It can have a profound, life-altering impact on patients, families, carers and health professionals everywhere, from rural pharmacies to urban hospitals. Many countries lack data about medication safety, which makes it difficult to design solutions to prevent harm. High-income countries are more likely to possess robust medication safety systems than low-income countries where resources are scarce. However, errors still occur frequently in areas with sound medication safety infrastructure, indicating that focused efforts to improve medication safety may diminish the threat, but have been unsuccessful at eliminating it. A systems approach is needed to build a safety net to can catch errors before they reach the patient and more importantly, prevent them from occurring, rather than solely rely on the actions of individuals.

This expert workshop on the Global Patient Safety Challenge on Medication Safety is coordinated by the Patient Safety and Quality Improvement unit at the World Health Organization (WHO). The purpose of this workshop is to deliver contextual background information about medication safety and provide an overview of specific components that will be targets for WHO action over the course of the Global Patient Safety Challenge. The launch will be the impetus to generate enthusiasm, obtain commitment from Member States, encourage collaboration among partners and engage international stakeholders to improve medication safety practices globally.

The expected outcome of this workshop is to illustrate the need for a Global Patient Safety Challenge on Medication Safety, provide an overview of the Challenge and outline intended actions to initiate strengthening of global medication systems. The Challenge will serve as an opportunity to concentrate efforts on the development and implementation of safe medication practices with patients and their carers, health professionals, international experts, policymakers and key stakeholders in academics and industry in patient safety and medication safety.

Chair: Prof. Sir Liam Donaldson

World Health Organization, WHO Envoy for Patient Safety, Geneva, Switzerland

Chair Information:

Professor Sir Liam Donaldson is recognised as an international champion of public health and patient safety. He was the foundation chair of the World Health Organisation's World Alliance for Patient Safety, launched in 2004. He is a past vice-chairman of the World Health Organisation Executive Board. He is now the World Health Organisation's Envoy for Patient Safety, Chairman of the Independent Monitoring for the Global Polio Eradication Programme, as well as Chairman of the Transition Monitoring Board of this Programme. In the UK, he is Professor of Public Health at the London School of Hygiene and Tropical Medicine, Honorary Distinguished Professor at Cardiff University, Associate Fellow in the Centre on Global Health Security at Chatham House, and Chancellor of Newcastle University.

Prior to this appointment Sir Liam was the 15th Chief Medical Officer for England, and the United Kingdom's Chief Medical Adviser, from 1998-2010. During his time in this historic post (established in 1855) he held critical responsibilities across the whole field of public health and health care. As the United Kingdom's chief adviser on health issues, he advised the Secretary of State for Health, the Prime Minister and other government ministers. He has produced landmark reports which have set health policy and legislation in fields such as stem cell research, clinical governance, quality and safety of health care, infectious disease control, patient empowerment, poor clinical performance, smoke free public places, medical regulation, and organ and tissue retention. He has published over 200 papers in peer-reviewed journals and is author of a standard textbook of public health that has been in continuous print for 30 years and co-author of the history of the Chief Medical Officers of England. He has made many media appearances as part of his professional roles.

Sir Liam initially trained as a surgeon in Birmingham and went on to hold teaching and research posts at the University of Leicester. In 1986, he was appointed Regional Medical Officer and Regional Director of Public Health for the Northern Regional Health Authority.

Sir Liam has received many public honours: 12 honorary doctorates from British universities, eight fellowships from medical royal colleges and faculties, and the Gold Medal of the Royal College of Surgeons of Edinburgh. He was the Queen's Honorary Physician between 1996 and 1999. He was knighted in the 2002 New Year's Honours List.

Co-Chair: Dr. Neelam Dhingra-Kumar

World Health Organization, Patient Safety and Quality Improvement Unit, Service Delivery and Safety Department, Coordinator, Headquarters, Geneva, Switzerland

Chair Information:

Neelam Dhingra-Kumar, MD, is Coordinator for the Patient Safety and Quality Improvement Unit, in Department of Service Delivery and Safety at the World Health Organization (WHO) headquarters in Geneva. In this role, Dr Dhingra leads WHO's efforts at providing strategic leadership on patient safety and quality improvement and strengthening system for safety and quality of health services globally. Dr Dhingra coordinates WHO's work for improvement of safety and quality of health care, including global patient safety challenge on medication safety, global networks, safety and quality tools and checklists, reporting and learning systems, patient and family engagement and patients for patient safety, leadership in patient safety and education and training. Since joining WHO in 2000, Dr Dhingra had been leading global initiatives for strengthening the delivery and safety of transfusion and laboratory services, as part of the broader health care system. Prior to that, Dr Dhingra served as a medical faculty in a large, tertiary care University Teaching hospital in New Delhi, India for 14 years. Dr Dhingra's areas of expertise are policy and strategy formulation; safety and quality of health services; vigilance, reporting and learning; quality and risk management; education and training; and assessments, monitoring, evaluation and operational research.

High-Risk Situations in Medication Safety

Philip A Routledge, Prof. Dr., All Wales Therapeutics and Toxicology Centre, Clinical Director, Wales, UK

Abstract:

The scientific literature indicates that the impact of medication errors is greater in certain clinical circumstances such as in hospital inpatients rather than in the community. This may be related to the more acute/ serious clinical situation and the wider use of parenteral administration of several medications. Young children and the elderly are more susceptible to adverse outcomes, as are those with concomitant renal or liver disease. Medication errors in these circumstances often involve the administration of the wrong dose, and not following agreed policies, such as not recording of body weight or not following prescribing policies. An increasingly important high risk situation is when patients with multimorbidity are receiving multiple medications (polypharmacy).

Particular medicines (high risk or high alert medicines) are highly represented in those causing adverse outcomes. Many expert bodies agree that these often involve 6 specific groups of medicines, Antiinfectives, Potassium & other salts/ electrolytes for injection, Insulins, Chemotherapeutic agents/ immunosuppressive agents and Heparin & oral anticoagulants („APINCH"). The development of local high-risk (high-alert) medication lists, regularly updated, helps healthcare professionals to focus on particular risks in their own workplace.

Because of the complexity of systems in health, The Institute for safe Medication Practice (ISMP) has highlighted that a single strategy for addressing the risks associated with each high-risk medication in the acute care setting is rarely sufficient and that several risk reduction strategies should generally be used together, choosing those that influence as many steps of the medication management system as possible.

Keywords: High risk situations, High risk (Alert) Medications

Speaker Information:

Phil Routledge graduated in Medicine (MB BS and MD) from the University of Newcastle upon Tyne and trained in general internal medicine and clinical pharmacology and toxicology in the UK and USA before being appointed in Cardiff in 1981, where he is now Emeritus Professor of Clinical Pharmacology in Cardiff University School of Medicine. He is also Clinical Director of the All Wales Therapeutics and Toxicology Centre in Cardiff and Vale University Health Board and works on prescribing, pharmacovigilance and medication safety.

Polypharmacy

Alpana Mair, FFRPS, IP, MRPharmS, Head of Effective Prescribing and Therapeutics, Scottish Government, Scotland

Abstract:
Safe and effective treatment with medicine remains one of the greatest challenges in medicine, where models of healthcare delivery lag behind the enormous growth in single disease focused treatment with medicines. The implications for safe, efficient and effective deployment of healthcare resources and sustainability are significant from both healthcare and societal perspectives. As many as half of all patients with long term conditions are using their medicines in a way that is not fully effective with resultant sub-optimal treatment of their condition and attendance or hospital admission. There is a significant level of inappropriate medicine prescribing which compounds the problem. In terms of emergency department attendances it has been reported that as many as 28% of such attendances were related to medicines with 70% being preventable. Similarly, it has been found that medicine related visits accounted for 12.5% of attendances, the main causes being adverse drug reactions (ADR) and non-adherence to medicines (33% and 19% respectively) . Worldwide, 3-6% of all hospital admissions are attributed to medicines and ranging from 2-19% have been recorded in the USA with two studies in the UK reporting 10.1%

This session will highlight the importance of addressing the public health issue of polypharmacy as part of a global medication safety challenge and its impact on patient safety addressing issues that are important for low and middle income countries and the crucial role that patients, healthcare professional and policy makers will need to make to have an impact on patient care. Tools that have been used to implement change such as guidelines and improve quality of prescribing will be discussed and shared.

Keywords: polypharmacy, multiple morbidities, guidelines, patients, policy makers

Speaker Information:
Alpana is currently Head of Prescribing and Therapeutics for Scottish Government. Key responsibilities include the coordination and delivery of Programme for Governments work on Prescribing and Therapeutics, linking in with Realistic Medicine and the NHS Scotland Clinical Strategy and advising Ministers on Quality of Prescribing. She leads and chairs the National Scottish Polypharmacy guidance, working to get this implemented as part of the core Scottish GP contract in a multidisciplinary approach, including development of a clinician and patient app to support medication review, and chair of the Royal Pharmaceutical Society report on Pharmaceutical care in Care homes. Alpana is leading a consortium across Europe for European funded project SIMPATHY, Simulating Innovation in the Management of Polypharmacy and Adherence in the elderly and is leading work for WHO on polypharmacy Global Patient Safety Programme. Alpana will lead the Special Interest Group on Appropriate polypharmacy for the Integrated Foundation of Integrated Care (IFIC) which will be launched at their annual conference in May 2017. Alpana coordinates a subgroup as part of the European Union work on Active and Healthy Aging on polypharmacy and medications adherence. Previously she was the Deputy Chief Pharmaceutical Officer for the Scottish Government. She works as an independent prescriber in Primary care running clinics for homeless patients to manage patients with multiple long term conditions and for patients with drug misuse. Alpana holds a clinical Masters in Clinical Pharmacy and in Advanced Leadership Practice from Harvard/ Napier University. She is a Scottish Quality and Safety fellow and an honorary lecturer at Strathclyde University, honorary senior lecturer at Robert Gordon University and Senior lecturer at School of nursing, Napier University, teaching on the non-medical prescribing course.

Key Causes of Medication Errors and Strategies for Improvement

Allen J. Vaida, BSc, Pharm. D, Dr., Executive Vice President, Institute for Safe Medication Practices, USA

Abstract:

This presentation will focus on examples of look-alike naming, packaging, and labeling of medications throughout the world, which are one of the key causes of medication errors. Many of these examples have been reported to the Institute for Safe Medication Practices (ISMP) National Voluntary Medication Errors Reporting Program. Others have been shared through the International Medication Safety Network (IMSN). All healthcare professionals as well as patients' experience mistakes when selecting or administering medications in error due to similar names, packaging, or labeling. Many of these errors, especially those that involve high-alert medications, may and often do, led to patient harm. Not all countries throughout the world may have reporting systems to help identify these hazardous conditions that may exist and actual errors that have occurred within their country, nor the network to share this information with others. The World Health Organization (WHO) is launching a Global Patient Safety Challenge on Medication Safety. A part of this challenge will be to address medication errors that occur due to naming, packaging, and labeling of medications. This will involve seeking global regulatory agencies to standardize on drug naming and labeling; to harmonize on drug bar codes, in order to distinguish medications on an international scale; develop local and national reporting and sharing programs that improve dissemination of guidance/safety reports; and develop local and/or ministry medication safety champions to help disseminate lessons learned.

Keywords*:* Medication safety, errors, harm, reporting, look-alike, naming, international, regulatory, high-alert

Speaker Information:

Allen J. Vaida is the Executive Vice President for the Institute for Safe Medication Practices (ISMP) in Horsham, PA, USA. Dr. Vaida has served on several national and international committees addressing medication safety; including on the United States Pharmacopeia's (USP) Safe Medication Use Expert Committee, the US FDA's Drug Safety and Risk Management Advisory Committee, and still serves as a special government employee for the US FDA. He holds adjunct faculty positions at the University of the Sciences in Philadelphia, Temple University School of Pharmacy, and Stanford University and Stanford University School of Medicine. He has given professional presentations and published on topics involving medication management and safety, error prevention strategies, culture, healthcare outcomes, integrated systems, and interdisciplinary collaboration. Dr. Vaida received a Bachelor of Science in Biology from the University of Scranton, a Bachelor of Science in Pharmacy from the Philadelphia College of Pharmacy and Science, and a Doctor of Pharmacy degree from the University of Minnesota.

Medication Safety in Resource-limited Settings

Priyadarshani Galappatthy, Prof. Dr., Faculty of Medicine, University of Colombo, Professor and Head Department of Pharmacology, Sri Lanka

Abstract:

Medication safety is a major concern contributing to patient safety particularly in resource-limited settings (RLS). Absence of reliable estimates of prevalence of adverse drug events, costs involved, causes of medication errors and evidence of effective interventions in RLS is a major limiting factor for ensuring medication safety in RLS. Although there are nearly five times as many people living in Lower and Middle Income Countries (LMICs), the number of annual adverse drugs events calculated (6 million) is almost equal to the number of adverse drug events occurring in high income countries (5.8 million). Some key problems identified include lack of reliable data, safety culture, reporting systems, poor reporting, poor legibility of hand written prescriptions, absence of electronic support systems, limited number of healthcare professionals to serve the large numbers of patients, lack of clinical pharmacists services, higher prevalence of counterfeit and substandard medicines (up to 20-30% in some LMIC countries), availability of large numbers of generics of the same drug, lack of stringent drug regulatory mechanisms, poor medication literacy and absence of patient support mechanisms.

Possible interventions include identification of the baseline situation on epidemiology and causes of adverse drug events in RLS, the drugs involved in RLS, their severity, amenability of drug events to prevention, implementing routine quality testing of drugs throughout the drug supply chain, implementing successful national drug regulation, increasing the capacity of regulators and providing technological support and expertise for detecting and managing drug related issues.

Expected outcomes would be establishing the baseline on the epidemiology of medication incidents in RLS, implementing systems and practices for medication safety and significant reduction in medication errors (e.g. up to 50%) in the next 5 years. Future direction is towards a multidisciplinary approach with active involvement of all stakeholders in preventing medication incidents. Developing and implementing an individualized action plan for each country for the problems identified based on local data would be the key to ensuring medication safety in RLS.

Keywords: medication safety, medication errors, resource limited settings, lower-middle income countries, prevention

Speaker Information:

Priyadarshani Galappatthy is a consultant physician, professor in Pharmacology and Head, Department of Pharmacology, Faculty of Medicine, University of Colombo, Sri Lanka. She has given leadership to several research and other projects on aspects related to improving medication safety working in collaboration with the Healthcare Quality and safety Unit, Ministry of Health and other stakeholders. These include initiating a medication incident reporting system, conducting a series of educational workshops, symposia and training courses for healthcare professionals and educating the public on medication safety.

Patient's Voice for Medication Safety – A Mother's Perspective

Maryann Murray, Patients for Patient Safety Canada, Volunteer, Canada

Abstract:

Maryann Murray will discuss the events that lead to the death of her daughter Martha at age twenty-two. Although the details are specific to one patient and one country, the events that occurred before and after Martha's death represent challenges faced by patients around the world and underscore the need to push for medication safety improvements on a global level. This experience is shared through a patient lens, discussing errors, irreparable harm, and cover-up as well as highlighting the importance of reporting systems, recommendations and collaborations which drive change. A period of ten years is covered, and although creating change is never easy, examples of patient engagement and public interest supporting initiatives leading to improvements are highlighted. This talk should serve as a reminder that the "numbers" in harm reports represent human beings, each of whom have suffered significant and often avoidable harm.

Keywords: patient, reporting, improvements

Speaker Information:

Maryann Murray holds a degree in History from the University of Western Ontario, Canada. She became focused on patient safety after the death of her daughter Martha in 2002. Maryann had questions on patient safety raised in the Legislative Assembly of Ontario and presented to the Standing Committee on Justice Policy. She is a Patient Champion of the World Alliance For Patient Safety, a WHO initiative and a founding member of Patients for Patient Safety Canada.

Notes

Organisation

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