WHO Patient Safety Movement & Patient Safety Rights Charter

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Global Patient Safety Movement – Past, Present and Future

Foundation (1998-2012)	Rejuvenation (2015-2018)	Watershed (2019)	Vision (2020-2030)
• To Err is Human • WHA Resolution (55.8), 2004 • 1st Global Patient safety Challenge (Clean Care – Safe Care) • 2nd Global Patient Safety Challenge (Safe Surgery - Save Lives)	• 1st Global Ministerial Patient Safety Summit London (Foundation) • 2nd Ministerial Summit, Bonn – Launch of WHO third Global Patient Safety Challenge: Medication Safety without Harm • **3rd Global Ministerial Summit, Tokyo (Tokyo Declaration)** • Global Patient Safety Network	• Patient Safety As a global health priority • **WHA 72.6 resolution on "Global Action on Patient Safety"** • World Patient Safety Day 17 September • 4th Ministerial Summit (Jeddah Declaration) • Patient Safety included on KSA G20 agenda	• **Global Patient Safety action plan 2021-2030** • WHO Flagship initiative "A Decade of Patient Safety" • 5th Ministerial Summit (Montreux, Switzerland) • Global Patient Safety Leaders Group on G20 agenda • Global Patient Safety collaborative: country cooperation and support • 6th Ministerial Summit (Santiago, Chile) • **WHO Patient Safety Rights Charter, 2024**

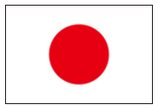
Series of the Global Ministerial Summit on Patient Safety

Seventh Global Ministerial Summit on Patient Safety (2025), Manila, Philippines

Sixth Global Ministerial Summit on Patient Safety (2024), 17-18 Apr 2024, Santiago, Chile

Fifth Global Ministerial Summit on Patient Safety (2023), 23-24 Feb 2023 Montreux, Swiss Confederation

Fourth Global Ministerial Summit on Patient Safety (2019), 2–3 March 2019, Jeddah, Kingdom of Saudi Arabia



Third Global Ministerial Summit on Patient Safety (2018), 13-14 April 2018, Tokyo, Japan

Second Global Ministerial Summit on Patient Safety (2017), 29-30 March 2017, Bonn, Germany

Patient Safety Global Action Summit (2016), 9-10 March 2016, London, United Kingdom

3rd Global Ministerial Summit on Patient Safety, Tokyo Japan, 2018

Patient Safety
Global Ministerial
Summit 2018

3rd Global Ministerial Summit on Patient Safety, Tokyo Japan, 2018

- The meeting was held under the leadership by the honorable Minister Katsunobu Kato, Japan who succeeded former Minister Yasuyuki Shiozaki on August 2017.
- The first Summit on Patient Safety held in Asian region.
- Five panel discussions were conducted with individual themes some of which were the same with the previous summit and others were newly taken up.

- Five panel discussion focused on “Patient Safety Culture”, “Patient Safety in Aging Society”, “Patient Safety Needs for Achieving Universal Health Coverage in Low-and Middle Income Countries (LMICS)”, “Information and Communication Technology (ICT) in Patient Safety”, and “Economics in Patient Safety”.
- “KAIZEN (Improvement)” was highlighted by illustrating large number of case studies in souvenir book.

TOKYO Declaration –The first declaration during the last three Summit Meetings

Third Global Ministerial Summit on Patient Safety, 13-14 April 2018, Tokyo, Japan

Tokyo Declaration on Patient Safety

This declaration is put forward by Japan, Germany, and the United Kingdom, and is endorsed by [Australia, Brunei Darussalam, Cambodia, Croatia, Czech Republic, Denmark, Finland, France, Greece, Indonesia, Kuwait, Lao People's Democratic Republic, Latvia, Lithuania, Luxembourg, Mexico, Mongolia, Myanmar, Netherlands, Oman, Philippines, Poland, Qatar, Saudi Arabia, Slovakia, South Africa, Spain, Sri Lanka, Switzerland, Thailand, Viet Nam, Asian Development Bank Institute, Japan International Cooperation Agency, Organisation for Economic Co-operation and Development, World Bank Group, World Health Organization, International Alliance of Patients' Organizations, International Council of Nurses, International Pharmaceutical Federation, Patient Safety Movement Foundation, and World Medical Association].

The Tokyo Declaration on Patient Safety is founded on the policies articulated in World Health Assembly resolution WHA55.18 (2002), which urges Member States to "*pay the closest possible attention to the problem of patient safety and establish and strengthen science-based systems, necessary for improving patient safety and the quality of health care*".

About 500 participants representing high-level government delegations from ministries of health, from 44 countries across the world and key international organizations, met on 13-14 April 2018 in Tokyo, Japan, to participates in the Global Ministerial Summit on Patient Safety 2018, organized by the Ministry of Health, Labour and Welfare, Japan with technical support from Germany, the United Kingdom of Great Britain and Northern Ireland, and World Health Organization. The Summit series was founded by the United Kingdom of Great Britain and Northern Ireland and the Federal Republic of Germany.

We welcome the vision and leadership of countries in building political sponsorship and momentum at the highest levels of government to address patient safety challenges globally, as well as locally. We reaffirm our commitment to improving patient safety in order to reduce all avoidable harm and the risk of harm to all patients and people during their interactions with health care systems, whoever they are, wherever they live, by 2030, and endorse the following Tokyo Declaration, while:

- Recognizing that unsafe health care and avoidable patient harm represent a serious challenge to health care service delivery globally, including the significant level of preventable human suffering, the considerable strain on health system finances and the loss of trust in health systems and in governments;

- Recognizing the need to promote and implement patient safety as a fundamental requirement of all service delivery systems, at all levels of health care and in all health care settings;

- Recognizing that patient safety is one of the most important components of health care delivery, which is essential to achieving universal health coverage (UHC), and moving towards UN Sustainable Development Goals (SDGs); and that patient safety systems and practices need to be established in all countries as one of the critical health care standards for achieving UHC on a sustainable basis;

1

- Noting the patient safety needs globally in acute care, ambulatory care including primary care, and community and home-based comprehensive care, with an integrated and people-centered approach for a successful health care system;

- Recognizing the vulnerability of elderly people to adverse events and the special needs of an ageing society in ensuring patient safety at all levels of health and social care;

- Noting the role that information and communication technology plays, from data collection and surveillance to monitoring and notification, anticipating risks, improved service delivery and improved safety and quality;

- Acknowledging that though health care systems differ from country to country, many threats to patient safety have similar causes and often similar solutions; thus signifying the need for cooperation among countries and institutions from the sharing of information and learning from patient safety incidents to the implementation of safe practices;

- Underscoring the importance of robust patient safety measurement systems, at all levels of health care including primary care;

- Emphasizing the importance of education, transparency and continuing training and learning of health care professionals to develop a competent and compassionate health workforce to deliver safe care – health workforce needs an appropriate labour environment to help make health care safe;

- Recognizing the role of engaging and empowering patients and families in the delivery of safe and quality care and in all aspects of health care - policy development, organizational level, decision making, health literacy and self-care.

As we are concerned that progress towards ensuring patient safety is too slow, despite the efforts made in each country, we call for greater commitment to accelerate progress towards improving patient safety globally.

We declare that we will:

Affirm our strong commitment to maintain a high level of political momentum on "Global action on Patient Safety" worldwide, and to work closely with countries across the world, including low- and middle income countries, in order to strengthen capability through collaboration and learning; and to prioritize patient safety in health sector policies and programmes while advancing efforts towards UHC;

Pledge to support and enable health care institutions, both public and private, from primary care level through to referral level care, to implement changes in systems and practices to improve patient safety, while contributing to achieving UHC and the SDGs;

Commit to building capacity in leadership and management to support patient-centered care, implement and strengthen patient safety systems and processes, create a culture of safety and transparency, align incentives, educate and train the health workforce in patient safety, engage patients and families, increase efficiency and minimize harm by sharing knowledge on risks, best practices and successful models;

2

We declare that we will:

Work collaboratively with patients and families who have been affected by harm, international organizations and other key stakeholders to increase visibility and work towards global action on patient safety, including the establishment of an **annual World Patient Safety Day, to be celebrated on 17 September each year**.

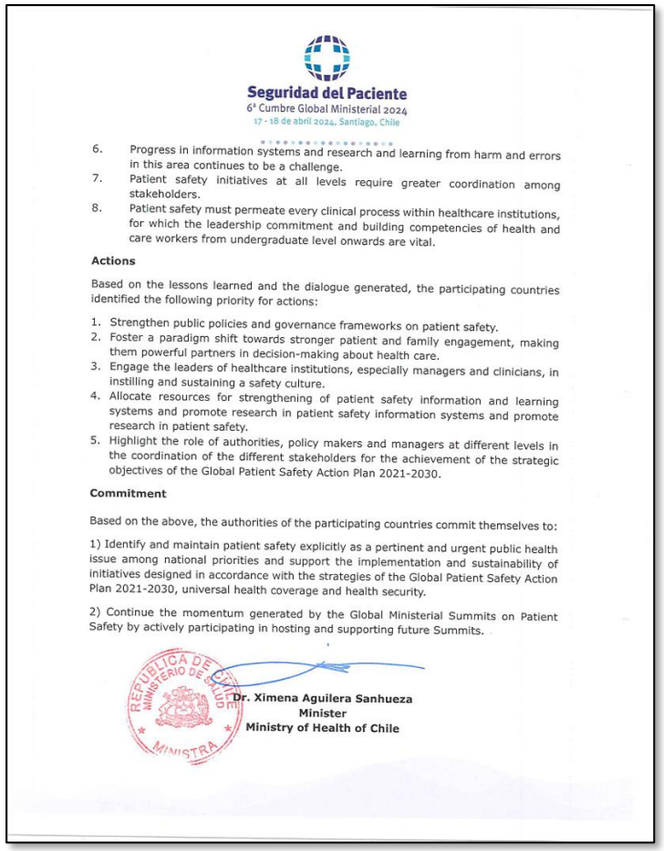
Ministerio de Salud
Gobierno de Chile

100 AÑOS SALUD Y SEGURIDAD SOCIAL

Patient Safety
6th Global Ministerial Summit 2024
17th - 18th April 2024, Santiago, Chile

6th Global Ministerial Summit on Patient Safety 2024, Santiago Chile

Santiago Commitment Charter on Patient Safety



Seguridad del Paciente
6ª Cumbre Global Ministerial 2024
17 - 18 de abril 2024, Santiago, Chile

6. Progress in information systems and research and learning from harm and errors in this area continues to be a challenge.
7. Patient safety initiatives at all levels require greater coordination among stakeholders.
8. Patient safety must permeate every clinical process within healthcare institutions, for which the leadership commitment and building competencies of health and care workers from undergraduate level onwards are vital.

Actions

Based on the lessons learned and the dialogue generated, the participating countries identified the following priority for actions:

1. Strengthen public policies and governance frameworks on patient safety.
2. Foster a paradigm shift towards stronger patient and family engagement, making them powerful partners in decision-making about health care.
3. Engage the leaders of healthcare institutions, especially managers and clinicians, in instilling and sustaining a safety culture.
4. Allocate resources for strengthening of patient safety information and learning systems and promote research in patient safety information systems and promote research in patient safety.
5. Highlight the role of authorities, policy makers and managers at different levels in the coordination of the different stakeholders for the achievement of the strategic objectives of the Global Patient Safety Action Plan 2021-2030.

Commitment

Based on the above, the authorities of the participating countries commit themselves to:

1) Identify and maintain patient safety explicitly as a pertinent and urgent public health issue among national priorities and support the implementation and sustainability of initiatives designed in accordance with the strategies of the Global Patient Safety Action Plan 2021-2030, universal health coverage and health security.

2) Continue the momentum generated by the Global Ministerial Summits on Patient Safety by actively participating in hosting and supporting future Summits.

REPÚBLICA DE CHILE MINISTERIO DE SALUD MINISTRA

Dr. Ximena Aguilera Sanhueza
Minister
Ministry of Health of Chile

Actions

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Experts' Plenary, Day1

6th Global Ministerial Summit on Patient Safety 2024, Santiago Chile

Dr. Ximena Paz Aguilera Sanhueza, Minister of Health, Chile

Dr. Teodoro Javier Herbosa, Secretary of the Department of Health of the Philippines

Dr. Ximena Paz Aguilera Sanhueza and Dr. Teodoro Javier

Patient Safety

72nd World Health Assembly (WHA), May 2019

Watershed moment for Patient safety !

- Adopted WHA Resolution on Global Action on Patient Safety (WHA72.6)
- Recognized Patient Safety as a “Global Health Priority”
- Established an annual World Patient Safety Day on 17th September
- Formulate a “Global Patient Safety Action Plan”, aligned with SDGs

World Health Organization

Purpose of the Global Action Plan

- Provide **strategic direction** for all stakeholders through policy actions
- Provide a **framework to develop national action plans** on patient safety
- **Align existing strategic instruments** for promoting safety in all clinical and health-related programmes
- Provide **implementation guidance** for mandate provided by WHO72.6: Global Action on Patient Safety

WHO Consultation Meeting, 24th-26th Feb 2020, WHO-HQ Geneva

Agenda: Development of Global Patient Safety action Plan 2021-2030”

Sir Liam Donaldson, WHO Patient Safety Envoy

The Rt Hon Jeremy Hunt, Former Chancellor of the Exchequer, UK

Dr Tedros, DG-WHO

GLOBAL PATIENT SAFETY ACTION PLAN 2021–2030

I. Policies to eliminate avoidable harm in health care
II. High-reliability systems
III. Safety of clinical processes
IV. Patient and family engagement
V. Health worker education, skills and safety
VI. Information, research and risk management
VII. Synergy, partnership and solidarity

Framework for Action - The 7x5 Matrix

1	Policies to eliminate avoidable harm in health care	1.1 Patient safety policy, strategy and implementation framework	1.2 Resource mobilization and allocation	1.3 Protective legislative measures	1.4 Safety standards, regulation and accreditation	1.5 World Patient Safety Day and Global Patient Safety Challenges
2	High-reliability systems	2.1 Transparency, openness and No blame culture	2.2 Good governance for the health care system	2.3 Leadership capacity for clinical and managerial functions	2.4 Human factors/ ergonomics for health systems resilience	2.5 Patient safety in emergencies and settings of extreme adversity
3	Safety of clinical processes	3.1 Safety of risk-prone clinical procedures	3.2 Global Patient Safety Challenge: *Medication Without Harm*	3.3 Infection prevention and control & antimicrobial resistance	3.4 Safety of medical devices, medicines, blood and vaccines	3.5 Patient safety in primary care and transitions of care
4	Patient and family engagement	4.1 Co-development of policies and programmes with patients	4.2 Learning from patient experience for safety improvement	4.3 Patient advocates and patient safety champions	4.4 Patient safety incident disclosure to victims	4.5 Information and education to patients and families
5	Health worker education, skills and safety	5.1 Patient safety in professional education and training	5.2 Centres of excellence for patient safety education and training	5.3 Patient safety competencies as regulatory requirements	5.4 Linking patient safety with appraisal system of health workers	5.5 Safe working environment for health workers
6	Information, research and risk management	6.1 Patient safety incident reporting and learning systems	6.2 Patient safety information systems	6.3 Patient safety surveillance systems	6.4 Patient safety research programmes	6.5 Digital technology for patient safety
7	Synergy, partnership and solidarity	7.1 Stakeholders engagement	7.2 Common understanding and shared commitment	7.3 Patient safety networks and collaboration	7.4 Cross geographical and multisectoral initiatives for patient safety	7.5 Alignment with technical programmes and initiatives

WHO Global Patient Safety Action 2021-2030

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14 | Global Patient Safety Action Plan 2021–2030

1.4
Safety standards, regulation and accreditation

1.5
World Patient Safety Day and Global Patient Safety Challenges

3.1
Safety of risk-prone clinical procedures

4.4
Patient safety incident disclosure to victims

5.1
Patient safety in professional education and training

6.1
Patient safety incident reporting and learning systems

World Health Organization

Global Patient Safety Report 2024

20%: Patient Safety

38%: Never Event/Sentinel Event Reporting

32%: Incident Reporting System

Progress in achieving the core indicators[1]

29%
Proportion of countries that have developed a national patient safety action plan or equivalent

20%
Proportion of countries that have incorporated a patient safety curriculum in education programmes or courses for health care professionals

38%
Proportion of countries that have established their national targets on reducing health care-associated infection rate

18%
Proportion of countries that publish an annual report on patient safety

38%
ortion of countries that implemented a system for orting of never events (or sentinel events)

18%
Proportion of countries that have signed up for implementation of the WHO Health Worker Safety Charter

13%
Proportion of countries that have a patient representative on the governing board (or an equivalent mechanism) in 60% or more hospitals

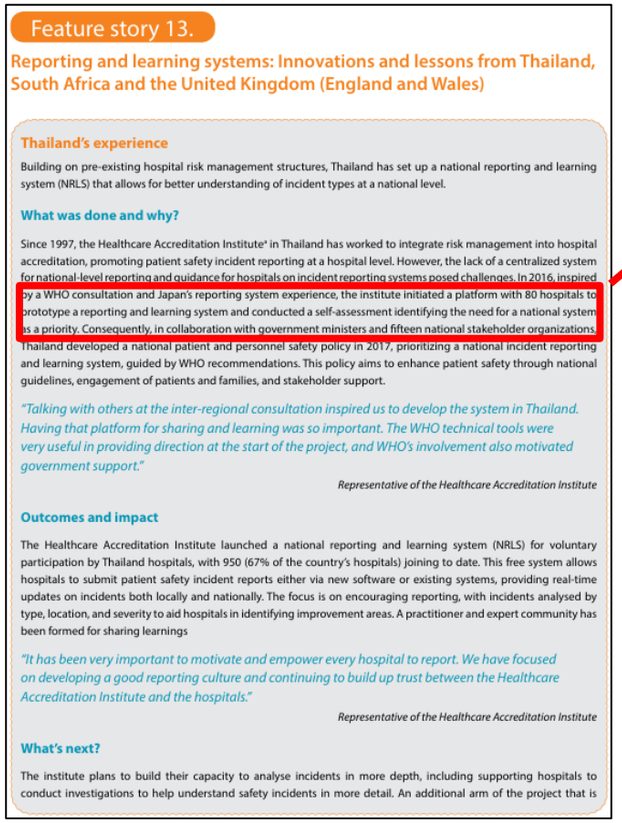
21%
Proportion of countries that have established a national patient safety network

21%
Proportion of countries that have established their national targets on reducing medication related harm

32%
Proportion of countries that have 60% or more health care facilities participating in a patient safety incident reporting and learning system

World Health Organization

Global Patient Safety Report 2024: Reporting and learning systems: Innovations and lessons from Thailand



Feature story 13.

Reporting and learning systems: Innovations and lessons from Thailand, South Africa and the United Kingdom (England and Wales)

Thailand's experience

Building on pre-existing hospital risk management structures, Thailand has set up a national reporting and learning system (NRLS) that allows for better understanding of incident types at a national level.

What was done and why?

Since 1997, the Healthcare Accreditation Institute[a] in Thailand has worked to integrate risk management into hospital accreditation, promoting patient safety incident reporting at a hospital level. However, the lack of a centralized system for national-level reporting and guidance for hospitals on incident reporting systems posed challenges. In 2016, inspired by a WHO consultation and Japan's reporting system experience, the institute initiated a platform with 80 hospitals to prototype a reporting and learning system and conducted a self-assessment identifying the need for a national system as a priority. Consequently, in collaboration with government ministers and fifteen national stakeholder organizations, Thailand developed a national patient and personnel safety policy in 2017, prioritizing a national incident reporting and learning system, guided by WHO recommendations. This policy aims to enhance patient safety through national guidelines, engagement of patients and families, and stakeholder support.

"Talking with others at the inter-regional consultation inspired us to develop the system in Thailand. Having that platform for sharing and learning was so important. The WHO technical tools were very useful in providing direction at the start of the project, and WHO's involvement also motivated government support."

Representative of the Healthcare Accreditation Institute

Outcomes and impact

The Healthcare Accreditation Institute launched a national reporting and learning system (NRLS) for voluntary participation by Thailand hospitals, with 950 (67% of the country's hospitals) joining to date. This free system allows hospitals to submit patient safety incident reports either via new software or existing systems, providing real-time updates on incidents both locally and nationally. The focus is on encouraging reporting, with incidents analysed by type, location, and severity to aid hospitals in identifying improvement areas. A practitioner and expert community has been formed for sharing learnings

"It has been very important to motivate and empower every hospital to report. We have focused on developing a good reporting culture and continuing to build up trust between the Healthcare Accreditation Institute and the hospitals."

Representative of the Healthcare Accreditation Institute

What's next?

The institute plans to build their capacity to analyse incidents in more depth, including supporting hospitals to conduct investigations to help understand safety incidents in more detail. An additional arm of the project that is

for national-level reporting and guidance for hospitals on incident reporting systems posed challenges. In 2016, inspired by a WHO consultation and Japan's reporting system experience, the institute initiated a platform with 80 hospitals to prototype a reporting and learning system and conducted a self-assessment identifying the need for a national system as a priority. Consequently, in collaboration with government ministers and fifteen national stakeholder organizations,

Japan's reporting system experience,

In 2016, inspired by a WHO consultation and Japan's reporting system experience, the institute initiated a platform with 80 hospitals to prototype a reporting and learning system and conducted a self-assessment identifying the need for a national system as a priority.

World Health Organization

World Patient Safety Day 2019-

World Health Organization

Themes of WPSD 2019-2024

2024: Improving diagnosis for patient safety

2023: Engaging Patients for Patient Safety

2022: Medication Safety

2021: Safe maternal and newborn care

2020: Speak up for health worker safety!

2019: Speak up for patient safety!

World Health Organization

World Health Organization

Theme of 2023 WPSD

Health Topics | Countries | Newsroom | Emergencies | Data | About WHO

Home / Campaigns / World Patient Safety Day / World Patient Safety Day 2023

Theme:

"Engaging patients for patient safety"

Slogan:

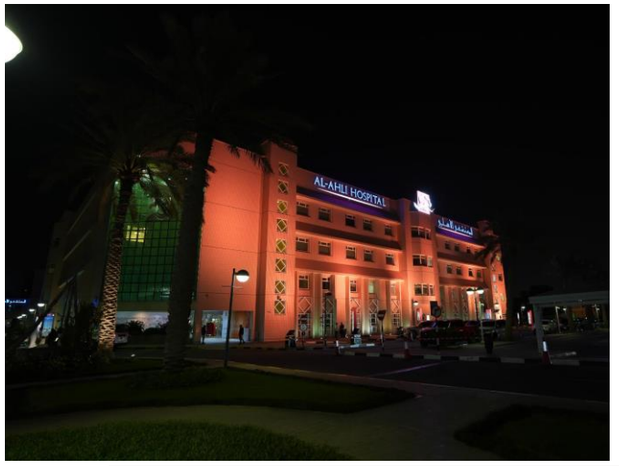
"Elevate the voice of patients!"

World Health Organization

WHO Global Conference-Engaging in Patient Safety, 12-13 Sep, 2023

World Health Organization


東京都庁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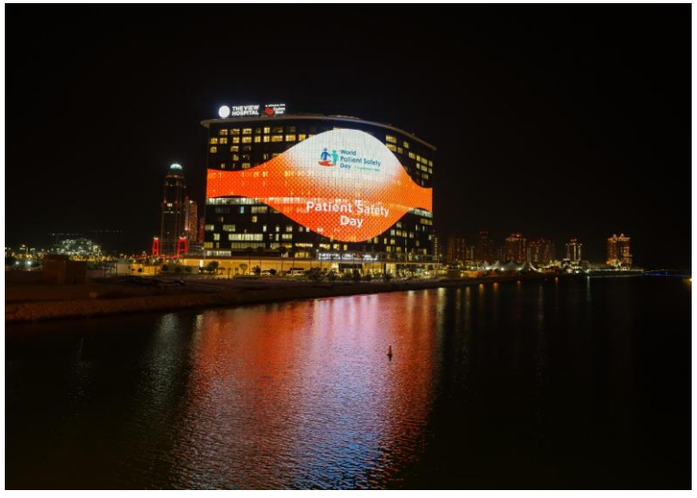

Patient Safety Day


福岡タワー


Naseem Medical Centre
مركز نسيم الطبي
Naseem
Medical Centre
نسيم


DOHA CLINIC HOSPITAL
IBN AL HAYTHAM PHARMACY

Annual congress of the Japan National University Alliance for Patient Safety (JANUHA-PS), Sendai 2022

Patient safety sub-committee, 15 Sep 2022, Kyushu University Hospital

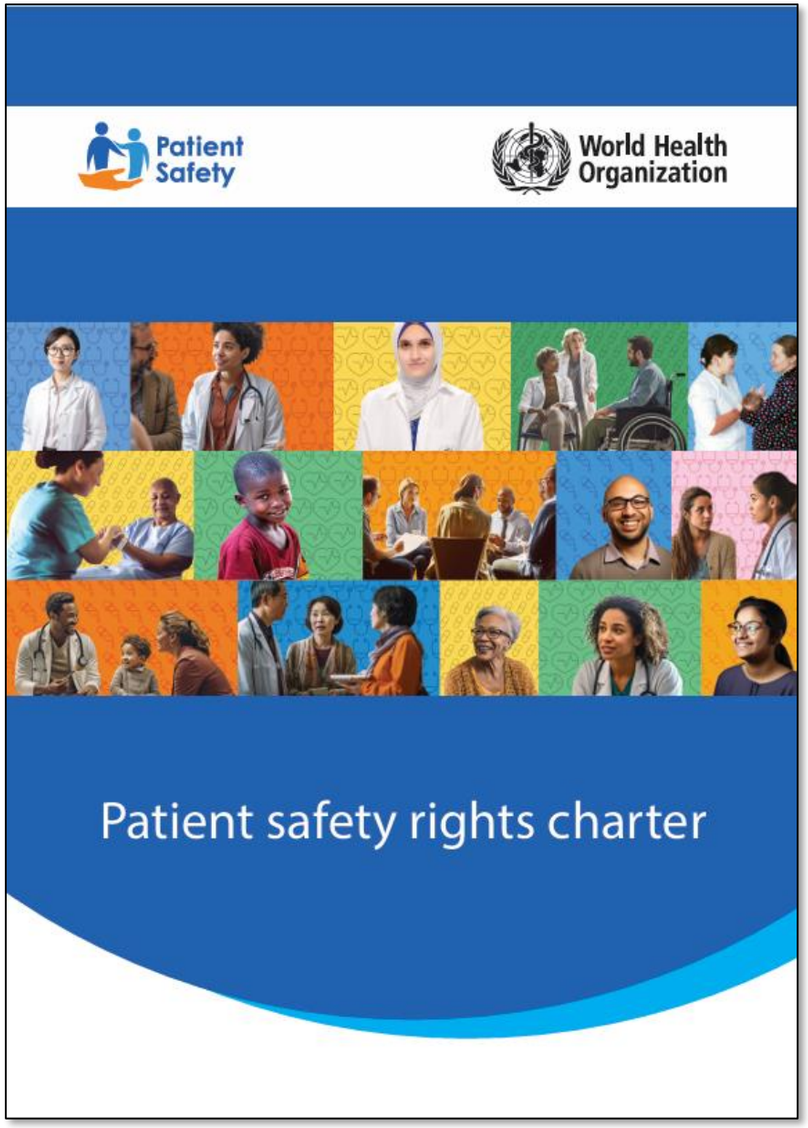
Memorial event & Discussion report to,

- MoHLW, Japan
- WHO（Through Campaign Site, Global PS Network）

World Health Organization


2023 Light-up of the
FUKUOKA Tower, 16th
Sep, Fukuoka Japan
さあ皆さん、あと10秒で、タワーがオレンジ色に変化しますよ。

Patient Safety Rights Charter 2024



10 Patient safety rights

1. Right to timely, effective and appropriate care
2. Right to safe health care processes and practices
3. Right to qualified and competent health workers
4. Right to safe medical products and their safe and rational use
5. Right to safe and secure health care facilities
6. Right to dignity, respect, non-discrimination, privacy and confidentiality
7. Right to information, education and supported decision making
8. Right to access to medical records
9. Right to be heard and fair resolution
10. Right to patient and family engagement

Human rights, health and patient safety

- Human rights are enshrined in various international instruments, including;
  - ✓ ***The Universal Declaration of Human Rights (1948)***
  - ✓ *The International Covenant on Economic, Social and Cultural Rights (1966)*
  - ✓ *The Convention on the Elimination of All Forms of Discrimination against Women (1979)*
  - ✓ *The Convention on the Rights of the Child (1989)*
  - ✓ *The Convention on the Rights of Persons with Disabilities (2008), and other international and regional treaties.*

Patient Safety Rights Charter 2024 - Development

- WHO Patient Safety Flagship in Geneva worked intensively on launching the Charter.
- It was launched in the 6th Global Ministerial Summit on Patient Safety in Chile on April 18, 2024.
- The document is intended to support the implementation of the Global Patient Safety Action Plan 2021-2030.
- It has been developed within the framework of World Patient Safety Day 2023 under the theme “Engaging patients for patient safety” and slogan “Elevate the voice of patients!”.

Patient Safety Rights Charter 2024 – Development (Cont'd)

- The Charter is an outcome of yearlong consultative process, engaging a diverse range of stakeholders, including patient advocates, patient safety experts, hospital safety experts, human rights experts, health workers, policy-makers and health care leaders.
- It is based on a comprehensive review of existing patient rights charters and legal instruments from across the world.
- A draft of the Patient Safety Rights Charter underwent critical review by the World Patient Safety Day 2024 Planning Group members and participants (in-person and virtual) of the WHO Global Conference "Engaging Patients for Patient Safety" which took place in September 2023.

Patient Safety Rights Charter: Objectives

1. Affirm patient safety as a core patient right, for everyone, everywhere.
2. Identify the key patient safety rights that health and care workers and health care leaders are to uphold when planning, designing and delivering safe health services.
3. Promote a culture of safety, equity, transparency and accountability within health systems.
4. Empower patients to actively participate in their own care as partners and to assert their right to safe care.
5. Support the development and implementation of policies, procedures and best practices that strengthen patient safety.
6. Recognize patient safety as an integral component of the right to health.

The Universal Declaration of Human Rights (1948)

Preamble

- Whereas recognition of the inherent dignity and of the equal and inalienable rights of all members of the human family is the foundation of freedom, justice and peace in the world,

The General Assembly,

- Proclaims this Universal Declaration of Human Rights as a common standard of achievement for all peoples and all nations, to the end that every individual and every organ of society, keeping this Declaration constantly in mind, shall strive by teaching and education to promote respect for these rights and freedoms and by progressive measures, national and international, to secure their universal and effective recognition and observance, both among the peoples of Member States themselves and among the peoples of territories under their jurisdiction.

Human rights, health and patient safety

- These instruments recognize and seek to uphold the fundamental principles of “equality” and “non-discrimination”.
- They safeguard the dignity and worth of every individual, regardless of their background, and on which all human rights are grounded such as the rights to;

  health, life, liberty, security, equality, privacy, education, freedom of expression, and much more.

- **In health care settings, patient safety is an important application of human rights norms and standards in relation to abovementioned decade-long established and preserved ideas.**

Key values related to health established in previous human rights instruments

- Right to **health**
- Right to **life, liberty and personal security**
- Right to **dignity**
- Right to **information**
- Right to **privacy**
- Right to **non-discrimination**
- Right to **freedom from cruel, inhuman or degrading treatment**

Patient safety and human rights

Right to health

- The right to health is the right of everyone to the enjoyment of the highest attainable standard of physical and mental health.
- All WHO Member States have ratified at least one international human rights treaty that incorporates this right.
- As a result, countries have a legal obligation to develop and implement legislation and policies that ensure universal access to safe and quality health services and to give due attention to the conditions that enable individuals to live in the best health possible.
- **Given that unsafe health care is a leading cause of morbidity and mortality worldwide, patient safety grounded in the ethical principle "First, do no harm" is an indispensable element of ensuring the safe engagement of patients with the health system and fulfilling the right to health.**

Patient Safety Rights Charter 2024 – 10 Rights

- Right to timely, effective and appropriate care
- Right to safe health care processes and practices
- Right to qualified and competent health workers
- Right to safe medical products and their safe and rational use
- Right to safe and secure health care facilities
- Right to dignity, respect, non-discrimination, privacy and confidentiality
- Right to information, education and supported decision making
- Right to access to medical records
- Right to be heard and fair resolution
- Right to patient and family engagement

Patient Safety Rights Charter 2024 – 10 Rights

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- **Right to be heard and fair resolution**
- Right to patient and family engagement

9. Right to be heard and fair resolution (excerpt)

- Patients have the right to share their experiences, file complaints and report safety incidents occurring during their care.
- Patients are to be provided with a supportive environment rooted in a culture of safety, whereby their voices are heard and their concerns expressed without the fear of retribution or negative repercussions.
- In the event of an incident, patients are entitled to clear explanations about what happened, the reasons behind it, and the actions taken for redressal, fair resolution and prevention of reoccurrence.

9. Right to be heard and fair resolution (excerpt, Cont'd)

- Patients also have the right to be involved in a fair and just process for addressing any harm experienced.
- This involves a clear pathway for independent investigation, accountability, reconciliation and fair resolution, including compensation in line with the harm experienced, national legislation and best practices.
- Appropriate mechanisms for reporting safety incidents and systems to learn from these incidents should be in place and functional.
- In cases of serious incidents, patients are entitled to receive ongoing psychological and other forms of support as needed, and should be reassured that the health care facility is committed to implement the learnings from the incident.

Structure and staffing to ensure patient safety and care quality

Director

Division of Patient Safety

Deputy director, **Chief Patient Safety Officer** (Doctor, full-time)

Divisional director (Doctor, full-time) , Deputy divisional director (Nurse, full-time), Safety managers (Nurse, Pharmacist, full-time; Dentist, concurrent)

Senior Patient safety officers (concurrent appointment) for;

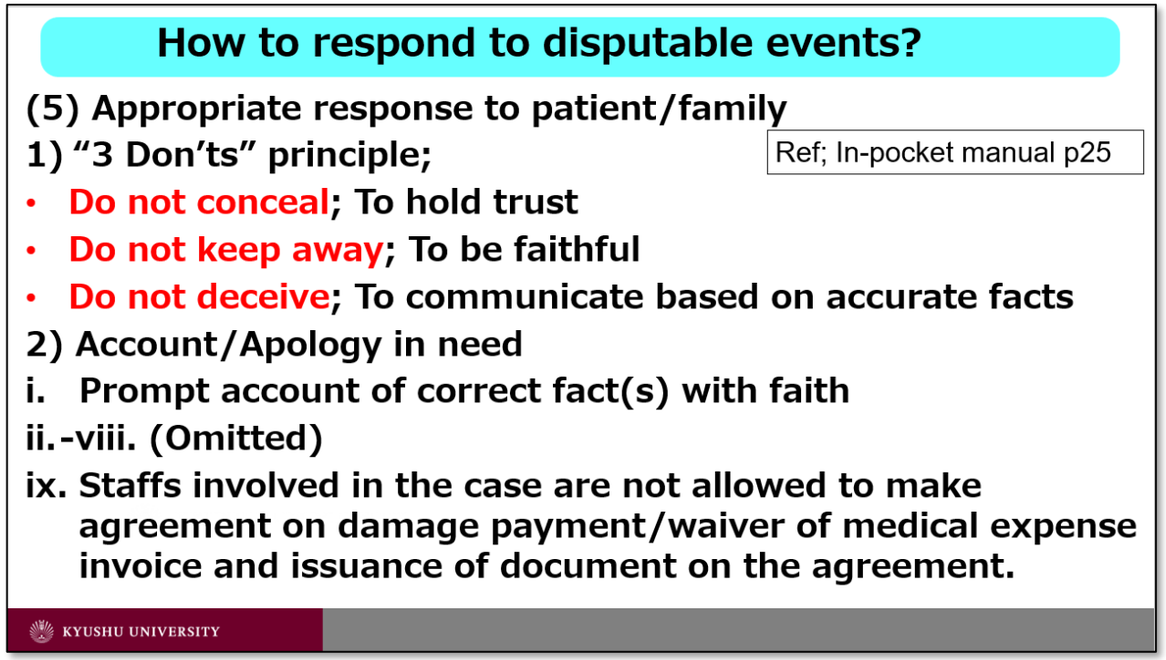
- Medication safety
- Radiological exam. and treatment
- Patient record and consent form maintenance

Risk managers (Doctor, Nurse, Dentist, Pharmacist, Radiologist, Therapist, Dietician, concurrent)

Procedures to respond to “disputable events” identified through incident reporting system, Kyushu University Hospital (KUH)

Principles:

- 3-Don’ts; “**Do not conceal**, **Do not keep away**, **Do not deceive**”
- “3-Don’ts” rule is a subject to learn in orientation course for fresh staffers at the beginning of new fiscal year.

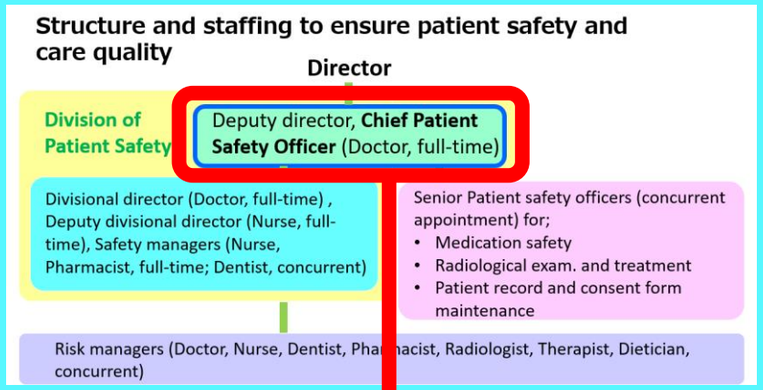


Slide for new employees’ orientation lecture

- **We may be reluctant to “3-Don’ts” when in troubled situation, however, we nevertheless need to follow it.**

Legal environment for facilitating dispute resolution

Kyushu University Hospital



Legal Firm contract

KEGO Legal Firm
(Lawyer, H.A., Lawyer, S.I., Lawyer, S.A.)

Jobs under contract;

- Consultation with KUH on dispute
- Attend internal meeting/committee on conflict management
- Work on conflict and lawsuit

Stakeholders' meeting

Joint committee on expediting trial process of medical case, FUKUOKA district court

Members;

- Relevant officers i.g. director, deputy director on patient safety of four university hospitals
- Plaintiff and defense Lawyers engaged in medical dispute
- Judges of FUKUOKA district and appeal courts

Insurance Firm contract

Indemnity insurance
SOMPO JAPAN

- **Insurance for National University Hospital Group (Annual premium: 50 million JPY = 360,000 USD)**
- Paid for;
  a. Damage payment for mishaps that staff involved in
  b. Damage payment for patient's property damage event

No-fault compensation/investigation/　prevention system for cerebral palsy , 2009～)

No-fault compensation (Insurance)

Petition (Report of CP) → Review → Payment

Proceeding irrespective of negligence

Investigation/Prevention with Patient Representatives

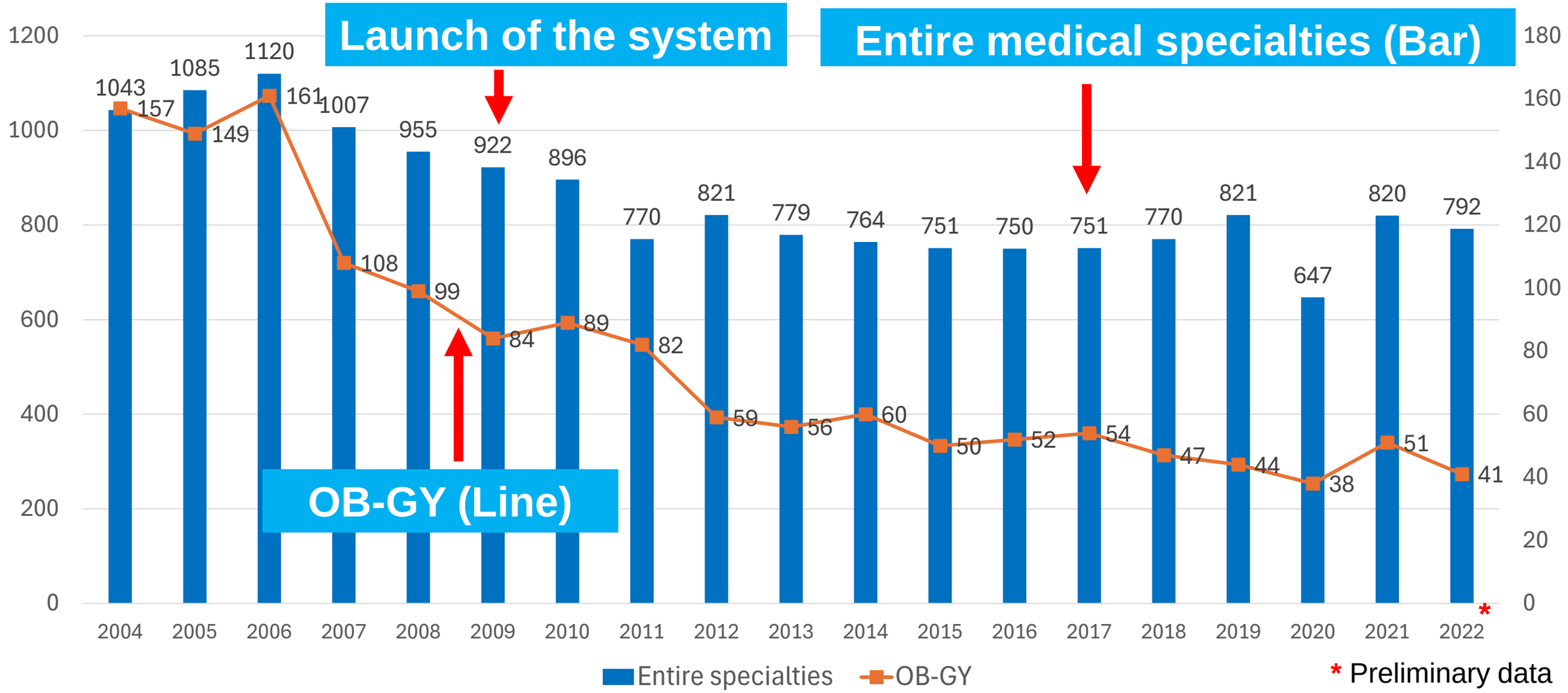
Medical chart, Birth care record, laboratory data, etc.

Family's Voices

20-30 pages

Prevention, early settlement of conflicts and Improvement of quality

Impact on lawsuit statistics on OB-GY



* Preliminary data

Statistics of lawsuit trend by medical specialties by the Supreme Court

Thank you！ Questions?

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