Kratis Training and Consulting Ltd

SCIENTIFIC CONFERENCE

PATIENT SAFETY

PREVENTION AND MANAGEMENT OF HUMAN ERROR IN HEALTHCARE

Nicosia, 25-26 January 2019

Abstracts Booklet

Redaction: Vassos Lappa

Note:
The coordination of the material included in this publication was based on the structure of the Conference Programme.

The respective authors are responsible for the content of each abstract.

ORGANISATION – CO-ORGANISATION – SUPPORT

The conference was organised by the company **Kratis Training and Consulting Ltd** in cooperation with the **Cyprus Medical Association (ΠΙΣ)** and the **Cyprus Nurses and Midwives Association (ΠΑΣΥΝΜ).**

The conference was carried out with the support of the Cyprus Bar Association, the Medical School of the University of Cyprus, the Department of Nursing of the Cyprus University of Technology, the Medical School of the University of Nicosia, the School of Medicine of the European University of Cyprus, the Department of Nursing of the Frederick University, the Pancyprian Federation of Patients' Associations and Friends (ΠΟΣΠΦ), the Cyprus National Bioethics Committee, the Cyprus Quality Assurance Department in Healthcare, the Cyprus Association of Private Hospitals, the Cyprus Physiotherapists Association, the Cyprus Ambulance Service, the Cyprus Psychologists Association, the Bank of Cyprus Oncology Centre and the Cyprus Organisation for Standardisation (CYS). The conference was conducted under the auspices of the honourable Minister of Health, Mr Constantinos Ioannou.

Scientific Committee

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2.	Nursing Services Directorate of the Ministry of Health	Dr Evanthia Georgiou Dr Melanie Charalambous
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11.	Pancyprian Federation of Patients' Associations and Friends (ΠΟΣΠΦ)	Mr Marios Kouloumas Mr Nicolas Philippou (Secretary)
12.	Cyprus National Bioethics Committee	Dr Constantinos Phellas
13.	Quality Assurance Department in Healthcare	Mrs Mary Kyriacou Georgiou
14.	Cyprus Assocation of Private Hospitals	Dr Markos Agathangelou
15.	Cyprus Physiotherapists Association	Mr Christos Bardis
16.	Cyprus Ambulance Service	Dr Riana Constantinou
17.	Cyprus Psychologists Association	Dr Stella Petronda Dr Mariza Hadjicharalambous
18.	Bank of Cyprus Oncology Centre	Mr Panos Ergatoudes
19.	Kratis Training and Consulting	Mr Vangelis Demosthenous Mr Solonas Demosthenous Mr Vassos Lappa

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1. Welcome speeches

1.1 Mr Vangelis Demosthenous, CEO, Kratis Training and Consulting Ltd

Last week, on the 18th of January, the Secretary of State for Foreign and Commonwealth Affairs of the United Kingdom, Mr Jeremy Hunt, who also served as Secretary of State for Health and Social Care, spoke at the 7th Annual World Patient Safety Summit that took place in California, United States. Among other things, he also mentioned a Campaign organised recently in the UK about sepsis, which resulted in saving 1600 lives.

I would like to open this conference by setting a goal: To have the opportunity to mention a lot of successes during our 2nd conference, next year.

About a year ago, when we started organising this conference, we didn't expect that it would reach this scale and we also didn't expect to receive such overwhelming support and enthusiasm from all bodies and institutions supporting this conference.

We would like to extend the warmest of thanks to the highly esteemed speakers from Cyprus and abroad, the 4 coordinators of the presentations as well as the members and moderators of the 4 break-out sessions panels, the members of the Scientific Committee, the sponsors and supporters of the conference and of course all of you who came here today.

We are standing before everyone who is involved in the healthcare sector with the utmost respect, and through our involvement in the conference, we appreciate their contribution even more.

Finally, I would like to thank the amazing Kratis team for giving of its best for this conference.
The conference was organised mainly for the following reasons:

- Information and training
- Creation and strengthening of patient safety culture and
- Gathering ideas and promoting a national patient safety plan for Cyprus

As far as patient safety is concerned, the contribution of everyone in this room is essential!

1.2 Mr Nicos Christidis, Marketing Director for Cyprus, Medochemie

1.3 Dr Petros Agathangelou, President of the Cyprus Medical Association

The President of the Cyprus Medical Association, Dr Petros Agathangelou, underlined the importance of the conference, which "touches an issue that all of us are thinking about, a lot of us discuss it in private but very few of us dare to talk about it in public. The matter of medical error is a taboo subject." At the same time, the President of CMA noted the high level of services provided in Cyprus, regarding which the medical world has been a catalyst.

1.4 Mr Demetris Syllouris, President of the Cypriot Parliament

1.5 Mr Constantinos Ioannou, Minister of Health

2. Abstracts

2.1 PART 1 - Why Patient Safety?

Coordinator: Dr Constantinos Phellas, Chairman of the Cyprus National Bioethics Committee, Vice Rector for Faculty and Research, University of Nicosia

2.1.1 Opening address

Dr Constantinos Phellas, Chairman of the Cyprus National Bioethics Committee, Vice Rector for Faculty and Research, University of Nicosia

2.1.2 The scale and impact of human error and negligence in Healthcare

Dr Ioannis Markou, Hellenic Air Force, NHS

2.1.3 Reporting and learning system in a Public Hospital in Cyprus

Mrs Mary Kyriacou Georgiou, Head of Cyprus Quality Assurance Department in Healthcare

In this speech, the development, implementation and evaluation of the Reporting and Learning System in a Public Hospital was mentioned, with the direct involvement of healthcare professionals in such a way that damages are reduced and patient safety culture is established.

The current situation is presented as well as the adoption of a strategy based on three pillars of action. Firstly, the adoption of a tool for measuring adverse events to be able to determine them. Also, the reports of healthcare professionals and users of the services are included in the system.

Reference is made to the manner in which the IHI Global Tool for Measuring Adverse Events of the Institute for Healthcare Improvement is implemented. The tool quantifies the degree of damage and severity and it is used as a guide for the decrease of damage and the measuring of adverse events in healthcare.

Additionally, since there is a growth of high correlation between patient safety and improvement of healthcare quality, including the change in organisational culture, the third pillar of the System's strategy is the data generated as clinical indicators, measured with a special tool (PATH) of the WHO.

2.2 PART 2 - Best practices in Patient Safety

(Coordinator: Dr Christiana Kouta, Cyprus University of Technology)

2.2.1 Opening address

Mr Ioannis Leontiou, President of Cyprus Nurses and Midwives Association

2.2.2 Measuring Patient Safety and Data Management

Prof Bryn Baxendale, Trent Simulation & Clinical Skills Centre, Nottingham University Hospitals NHS Trust

Gaining a more comprehensive understanding about the safety of care provided in the NHS and how to support its improvement has been a focus of national strategy and policy for several decades, facilitated by key publications such as *An Organisation with a Memory* (2000). This led to the establishment of the National Patient Safety Agency (NPSA) and introduction of the national reporting and learning system (NRLS), which resulted in local healthcare provider institutions introducing local incident data collection and reporting. Data was published publicly and national standards were introduced to enable external scrutiny of performance against these measures by different healthcare regulatory bodies. A broader focus on quality of care was developed subsequently with quality indicators including indices of patient safety and mortality, alongside new measures of patient and public perception of their experience of healthcare, and financial incentives were introduced to try and drive improvement in specific identified causes of patient harm. Whilst this attention and resource was associated with some notable successes over this period in relation to healthcare acquired infections (for example), the overall picture relating to patient safety remained extremely stubborn to establishing or sustaining the levels of improvement desired.

What has become clear from reviews of the patient safety literature is that the early focus on past harm and mortality has been somewhat contentious in terms of how the data has been interpreted and has been recognised as not providing the full story when trying to understand the causes of avoidable harm. Particular criticism has highlighted that these measures focus on past performance (so called ‘lag measures’) and offer limited insight into likely or predicted future performance when introducing or evaluating changes in practice designed to drive improvement. This has led to recognition of the influence of the different contexts and complexity in which care is provided that has not always been apparent within the ways in which past harm or mortality data have been collated and analysed.

Drawing on lessons and practice in a range of safety-critical industries, there is increasing attention being paid to understand how safety is created in daily clinical practice despite the many challenges and constraints faced at the point of care. This approach draws on disciplines such as Human Factors (Ergonomics) and Resilience Engineering, which offer a systems-based focus on how patient safety is an outcome of the design of healthcare systems and conduct of work. It also emphasises the ways in which healthcare staff act as a source of adaptability and flexibility to respond to different safety hazards. A framework on patient safety measurement and monitoring published in 2013 attempts to draw these themes together and illustrates how data might offer a more predictive picture of future safety performance ('lead measures') and enhance how past harm and mortality data might inform organisational and professional learning in a more proactive manner. This framework recognises the value of a national data collection system but recommends offering some local adaptability to provide recognition of different care contexts.

2.2.3 Success stories in Patient Safety - Manchester Bombing – Teamwork, Preparation and Planning

Dr Stephen Playfor, Paediatric Intensive Care Unit, Royal Manchester Children's Hospital

The Royal Manchester Children's Hospital (RMCH) was well-prepared for the bombing of the Manchester Arena on 22 May 2017 because of our commitment to major incident planning and our local experience in managing trauma. A total of 34 children were seen in our Emergency Department, 14 were admitted to the hospital, 6 of whom required Critical Care. All children were suffering from shrapnel wounds.

The major lessons learned from the incident included: An awareness of the impact on the wider organisation, at all levels. The importance of regular MDT meetings to discuss in detail the on-going requirements of patients. The importance of patient identification and communication. An awareness of the limitations of triage scoring systems, especially once patients are admitted to hospital. The uncovering of 'bottlenecks' within the system, not readily identified during exercises. The importance of liaison with external bodies; both medical and non-medical. The crucial importance of psychological support not only for patients and their families, but for staff members.

Our experience highlights the importance of having flexible, pragmatic staff on the ground during major incidents, and how training staff in these skills is at least as important as having a detailed major incident plan within a healthcare organisation.

2.2.4 The Domino Effect of Medical Errors

Dr Samer Ellahham, Cleveland Clinic, Abu Dhabi

Medical errors (MEs) are often defined as “an act of omission or commission in planning or execution that contributes or could contribute to an unintended result.”1,2 MEs are associated with a high rate of morbidity, mortality, and economic burden on the community. The Centers for Disease Control and Prevention stated that MEs are the third most common cause of death in the United States.3 The total annual cost of measurable MEs in the United States was found to be more than $1 billion in 2009.4 A ME negatively affects all stakeholders in the health care industry, creating a domino effect (Figure 1). Patients, their families, health care team members, health care organizations and management, and the community equally share the burden of the ME. For example, in an ill-fated incident (September 2010), a critical care nurse in Seattle Children’s Hospital accidentally gave a sick baby a fatal dose of calcium chloride. The incident resulted in the death of the 8-month-old child; the nurse was later fired. The nurse was refused work despite having 27 years of pediatric experience. Seven months later, the nurse committed suicide. 5 Moreover, the integrity of the hospital was questioned and it had to pay a hefty fine. The community’s faith in the nursing profession was shaken and the risks associated with the nursing profession were elucidated. This example highlights that ill effects of MEs are not limited to patients, families, and health care providers (HCPs). Rather, they extend beyond and affect supporting staff, the institution, and the community.

2.2.5 Incidents in the Healthcare Sector – Management, Investigation and Just Culture

Mr Vangelis Demosthenous, Kratis Training and Consulting Ltd

Unfortunately, in Cyprus there are no systems in place for the management of incidents and errors in the healthcare sector. As a result, many of these incidents are not reported, they are not investigated and thus no corrective measures are taken in order to prevent them from happening again. By way of a case study, the following questions are asked:

- How many incidents are reported in the healthcare sector?
- What do the Health Services learn from these incidents?
- In what degree is the prevention and/or management of this type of incidents improved?
- In what way do the rest of the healthcare professionals benefit and learn from these incidents?

The incident management systems, or better yet the safety systems, have to help us **learn both from incidents and from almost incidents** and also from **existing situations and conditions** that could

cause the incidents. Through this process, we should investigate not only the type of incident and errors made but also, even more, the **factors that lead to** them.

Two necessary conditions for the success of the above mentioned are: firstly, the existence of **a reporting system for incidents**, errors and other patient safety matters. It is important that these systems are created both at a national level and in every health institution. The second condition is the creation of a ***just safety culture/approach*** where health professionals report incidents and errors without being afraid of unfair treatment.

2.3 PART 3 - Creating a Culture of Patient Safety

(Coordinator: Mr Panos Ergatoudes, Bank of Cyprus Oncology Centre)

2.3.1 Opening address

Mr Marios Kouloumas, President of the Pancyprian Federation of Patients' Associations and Friends (ΠΟΣΠΦ)

On behalf of ΠΟΣΠΦ, I would like to congratulate the organisers of this very important conference that deals with a serious public health issue concerning which, unfortunately, in our country we are facing a lot of gaps and shortcomings, just like many other public health issues.

Indeed, as the title of the lecture suggests, what is needed apart from the legislative arrangements, procedures and policies, is to build a patient safety culture among everyone involved in health matters.

The European Charter for the Patients' Rights for the safety right states: Everyone has the right to be exempted from any damage caused because of the poor functioning of health services, of erroneous medical actions and errors. Everyone has the right of access to services and treatments that adhere to high standards in the healthcare sector.

The term patient safety means the protection of patients from additional problems or possible damages relative to healthcare.

If patients are asked, in their great majority, they mention that themselves or a member of their family has had at least one negative experience relative to healthcare services. And unfortunately they don't know which authority – is there any? – is responsible for the safety of patients in Cyprus.

The safe care of patients constitutes the most important challenge within the healthcare sector today. Even though there is a revolution in healthcare, with state-of-the-art technologies, which can save lives, at the same time they can potentially threaten the health and life of a patient.

Adverse events in healthcare can potentially gravely affect every patient and their families and they constitute a very important burden for health and welfare funds.

Therefore, the implementation of policies and good practices will protect the health and lives of patients and it will significantly decrease health expenditure.

Patient safety constitutes an important aspect of the provision of quality care as well as an essential element of quality: High quality health services, focusing always on the patient and his/her needs.

In the healthcare sector, each patient should feel safe and secure and should know that clear and effective procedures are in place as well as international operation and quality standards.

Patient safety is not only a medical affair but also something that concerns everyone involved in health matters. And, in the context of the implementation of the General Healthcare System (ΓεΣΥ), it should primarily concern the competent body as well as the public health system as a whole.

Therefore, it concerns each and every organisation individually and collectively, in every level and involving all personnel and everyone responsible for the drawing up of health policies but most of all the patients themselves and their representatives. The patients themselves should participate and help in the efforts of improvement of the health services provided.

Aiming to drastically decrease medical errors and give prominence to safety issues as our priority, measures and policies should be promoted towards this goal.

Hence, a medical error should not be seen as a matter of punishing someone, differentiating it of course from criminal negligence, but as a means of correcting the system and not repeating the same mistake. That is indeed to do with the culture we need to create and, instead of hiding the errors, on the contrary they need to be pointed out and be a part of gained knowledge and training.

I am certain that we will listen to many important things on behalf of the esteemed speakers and I hope that this conference constitutes the first step towards the promotion of patient safety measures.

Life and health are precious, they should be protected and you should keep in mind that behind the numbers and statistics about adverse events, there is always a person and his/her family who are experiencing the impact of that error.

2.3.2 Opening address

Mrs Athina Panayiotou – Managing Director of the Cyprus Certification Company (ΚΕΠ), on behalf of Mrs Kikoula Kotsapa, Chairman of the Board of Directors of the Cyprus Certification Company (ΚΕΠ)

What affects patient safety? This does not only involve the doctor and a correct diagnosis. There are many factors that affect the issue of patient safety positively or negatively and one of these factors is culture. Admittedly, all along, every attempt to change this culture has been difficult with a lot of challenges.

Therefore, it is important to have tools which can provide assistance in this effort and can improve the level of healthcare services, providing thus a greater incentive to healthcare professionals and

everyone involved. Such tools that can be implemented in the healthcare sector are the standards developed by European and international standardisation bodies but also the specialised standards that include analytical requirements for the organisation and management of quality and safety in healthcare services.

The standards are documents that contain specifications for products, services and procedures, which are developed by European and international standardisation bodies with the involvement of experts from all around the world. In Cyprus, the national standardisation body is CYS (Cyprus Organisation for Standardisation), a private company which has a single shareholder, the State, and which is a full member of the European and international standardisation bodies. The mission of CYS is to promote the implementation of the standards in every sector of the economy and the society.

The Cyprus Certification Company (ΚΕΠ), subsidiary of CYS, is the government body for certification in Cyprus and it operates in the sector of certification of health services with different international and European standards of management systems, while at the same time, during the last ten years, it has an exclusive cooperation with the British organisation CHKS, which is accredited by ISQua (International Society for Quality in Healthcare) and it offers certification/accreditation of hospitals based on specialised standards.

Both the management systems standards and the specialised standards of organisations accredited by ISQua, contribute to the promotion of patient safety culture, since they include specific requirements relevant to organisation matters for health services, resources, powers and responsibilities, communication and training. In addition, the specialised standards of CHKS determine certain requirements concerning the journey of a patient in a hospital as a whole and the management of potential risks likely to arise, ensuring thus the patient's safety.

From our own experience, it is very positive that, in recent years, there is an increased interest of both the private and the public sector concerning the implementation of such standards. Moreover, it is extremely important that this conference is taking place during a very critical time for our country due to the upcoming changes. As far as we are concerned, both as the Cyprus Certification Company and the Cyprus Organisation for Standardisation, we will contribute in any way we can to the improvement of patient safety and healthcare services in Cyprus in general.

2.3.3 Appreciative Inquiry, Staff Morale and the Impact of Patient Safety

Dr Constantinos Kanaris, University Hospital North Midlands

Patient Safety is a core responsibility of anyone working in healthcare. Stereotypically attempts to improve patient safety have tended to focus on learning from error. Even the famous axiom "Primum non Nocere" refers to focusing on harm avoidance rather than doing good.

Intuitively, this seems like a reasonable idea: if we err, we would like to understand the factors leading up to that error, learn from it and implement processes that stop it from being repeated, after all as per Menanander's dictum «Το δις εξαμαρτείν ουκ ανδρός σοφού» (to make the same mistake twice is not an attribute of a wise person)

Mistakes, however, only happen in a minority of clinical encounters; so learning purely from errors limits our ability to learn and improve on matters relating to patient safety. What we often miss out on is learning from occasions where patient care was excellent.

By learning purely from adverse events we also risk creating a culture of fear, poor morale and negativity. This exacerbates emerging problems within healthcare, namely staff burnout and retention.

I aim to challenge the notion that learning from errors is the main tool at our disposal to improve quality in healthcare and patient safety. I shall also explore the concepts of negativity bias (why we are innately drawn to spot mistakes); the second and third victim phenomena as well as the value of Appreciative Inquiry. The latter is the process whereby we learn from when things go well. I will use the example of the Excellence Reporting system implemented on our paediatric intensive care unit and what effect it has had on patient care.

2.3.4 Importance of Training and CRM simulation training in Patient Safety

Prof Bryn Baxendale, Trent Simulation & Clinical Skills Centre, Nottingham University Hospitals NHS Trust

The quality and safety of modern healthcare has always relied upon having a workforce with appropriate capabilities to meet the needs of patients and the clinical services offered within an institution or the wider healthcare system. At a time when medical knowledge is increasing rapidly this presents a problem for practitioners to remain up-to-date with the expanding evidence base. In addition there are dramatic developments in the fields of healthcare and information technology, which subsequently influence the range of options for clinical management of many conditions as well as the ways in which healthcare professionals work and clinical services are provided.

Traditional models for educating healthcare professionals have focused on the knowledge and technical skills they need to undertake the role they will undertaking in clinical practice. In recent years the patient safety literature has highlighted the importance of attending to the development of broader professional capabilities ('non-technical skills') that underpin safe, effective working for any practitioner, especially when dealing with complex or challenging situations. This focus on individual capabilities

has also broadened to explore in more depth the ways in which healthcare teams work together effectively to support safe care and how these skills and behaviours can be developed and embedded, drawing heavily on the literature and experience from other safety-critical industries.

Simulation is a proven and powerful tool for learning that can be applied to patient safety for individual and team-based practice as well as at an organisational level. The term 'simulation' represents a broad spectrum of educational technologies, techniques and experiential learning formats that can be accessed remotely or within different environments. These might be classrooms, clinical skills or fully immersive simulation facilities, or in the workplace itself ('in situ' simulation). Different simulation-based educational interventions can be beneficial for healthcare students, trainees and qualified staff and can support lifelong learning for the workforce if designed to meet specific needs. As a training intervention, it can enhance the development of basic or more advanced technical and non-technical skills and capabilities across different staff groups and roles.

Simulation also has an important role in the understanding and subsequent application of Human Factors (i.e. systems science) in the workplace to optimise professional practice, system performance and staff well-being within an increasingly complex and resource constrained clinical environment. This can help improve the quality and safety of patient care through studying interactions between individuals or multiprofessional teams and wider system factors in their work setting, offering a unique opportunity to evaluate and improve the design of medical devices, information technologies, working environments, and the policies and procedures that underpin everyday practice.

2.3.5 Patient Safety at the bedside -Introduction of Care Bundles

Mrs Suzanne Dunne, Our Lady's Children's Hospital Crumlin, Dublin, Ireland

Introduction: Prevention of healthcare-associated infection is a widely recognised indicator of quality care. Care-bundles are a set of evidence based interventions to reduce device-related infection. Care-bundles were successfully introduced to our organisation's the intensive care units and resulted in a reduction in device-associated infections. Similar surveillance data were not available for wider hospital.

In 2014 a patient safety project involving the implementation of care-bundles for four invasive devices hospital wide was rolled out. The aim of the project was to chart the

entire journey of the device from insertion to removal, and to generate device-related surveillance data.

Method: An action-research methodology was used to implement the four bundles across all areas on a phased basis. The project team developed bundle tools and surveillance forms, which were piloted in a cross-section of clinical areas before being implemented hospital-wide. An education programme was delivered by the project team. Surveillance data on numbers of devices, device infection-free days and infection rates were gathered. Reports are prepared collectively for the organisation and individually for each clinical area, and are displayed on quality boards for staff and parents. Since 2017 hospital wide Care bundle reports are provided to the Board of Directors on a quarterly basis.

Results: The four care-bundles have been successfully implemented hospital-wide. Device infection-free days are now known to all areas. Sustainability of the project remains an organisational patient safety priority as we move towards a new National Children's Hospital in 2022.

2.3.6 Safety culture, examples of implementation of patient safety practices

Dr Mina Ntantana, ICU Papageorgiou Hospital, Greece

We have decided to implement a patient safety management programme in our hospital, in an attempt to focus on safety matters that we consider to be crucial and that require intervention. It is a given that nurses, because of their role contributing a large part of their clinical action in all healthcare procedures, being active members in every multidisciplinary team, being next to the patient's hospital bed most of the time and operating the equipment for every kind of intervention, are the best placed healthcare professionals to operate the accident prevention and patient safety systems. Therefore, we have created special interest teams consisting of nurses. The teams were responsible for dealing with their topic of interest closely and in-depth and of course are still active. Their role was to plan, organise, train nurses, implement the plan, check the plan's progress, collect and study information and propose interventions in order to improve the hospital's safety practices and policies.

The special interest teams concern the prevention of accidents in the Operating Room, prevention of thrombophlebitis, prevention of patients' collapse and bed rest treatment.

In my speech, I will present the manner in which the entire practices development plan for patient safety management is organised as well as its results.

2.4 PART 4 - Legal Issues

(Coordinator: Mr Yiannos Georgiades, Georgiades & Associates LLC)

2.4.1 Opening address – Lessons learned from court cases in Cyprus

Mr Theodoros Ioannides, President of the Cyprus Bar Association

2.4.2 Good practices for the prevention and management of legal measures in healthcare

Mr Nikolaos Dialynas, Law offices Dialynas A. Nikolaos, Athens

2.4.3 Strategies to reduce clinical negligence claims (for lawyers and healthcare professionals)

Dr Stephen Playfor, Paediatric Intensive Care Unit

Clinical negligence claims cost the UK NHS around £1.7 billion each year, around 1.4% of the entire NHS budget. Most of the cost to the NHS Litigation Authority (NHSLA) arises from obstetric claims and it has been suggested that 76% of babies who suffered a brain injury or died in labour or the neonatal period would have had a better outcome but for avoidable errors. The NHS has committed itself to a 5-year strategy to 2020 of 'Delivering Fair Resolution and Learning from Harm'.

From a clinician's perspective claims may be either the result of a clear breach in the standard of care, resulting in harm, or the result of conflict between patients, their families and the clinical team. Breaches in the standard of care are mitigated by developing safer healthcare systems and investing in training, whilst conflict between patients, their families and the clinical team is primarily reduced through improved communication.

A number of factors combine to serve as risk factors for conflict and clinical negligence claims; these include the prevalence of complex chronic disease and potentially inappropriate care. Certain warning signs may be evident very early in a hospital

admission that make subsequent conflict more likely; these include both family and clinician behaviours.

Improved communication strategies with early apologies and disclosure, and the use of alternative dispute resolution methods appear to be very effective in reducing clinical negligence claims.

3. Break-out Sessions

Within the framework of the Conference, four (4) Break-out Sessions were carried out, during which the participants discussed targeted topics concerning Patient Safety that resulted in specific recommendations presented to the plenary of the conference. These recommendations are mentioned below.

3.1 Break-out Session 1 – Legislative and Regulatory Framework, Policies, Procedures, Instructions

3.1.1 Legal – Regulatory Framework

- Creation of a legislative framework and/or regulations regarding the quality requirements that should regulate the operation of public and private hospitals
- Establishment of a legislative framework for the licensing and operation of rehabilitation centres – Clarification as far as nursing homes are concerned since not all the patients are elderly and not all elderly are patients
- Inclusion in the legislation and/or reference to internationally recognised standards that can be implemented in healthcare services in terms of quality management, safety etc.
- Carrying out activities by the competent ministries regarding an information campaign as well as effective control of the existing legislations, e.g. the Law on Safety and Health at Work of 1996 and the Law on the Safeguarding and Protection of the Patients' Rights of 2004
- Conducting an investigation concerning the degree of implementation of the existing legislation and presentation of the results to everyone involved
- Provision of incentives to healthcare services for the implementation of systems, their certification as well as the carrying out of activities aiming to enhance patient safety and improve their services

- Establishment of a system for testimonials and referrals to experts, for the notification of data to the patient and establishment of protection provisions of the persons involved in legal cases
- Creation of an extra-judicial mechanism for the resolution of disputes with a multidisciplinary approach of expertise and the coordination and funding from an independent body

3.1.2 Policies, Procedures, Instructions

- Systematisation of internal operation procedures and organisation of health services as well as establishment of minimum documentation requirements – Implementation of internationally recognised standards
- Establishment of internal control procedures for the verification of compliance with the legislation and mistake and error prevention procedures
- Establishment of measurable indicators for the evaluation of the effectiveness of implemented procedures and the laying down of corrective actions

Implementation of information, training, promotion of quality culture and patient safety culture measures.

3.2 Break-out Session 2: Education, Training and Research

3.2.1 Education

- Inclusion of courses in the programmes of study of healthcare professionals concerning knowledge, attitudes and skills they should acquire in order to defend the safety of their patients e.g. WHO's Patient Safety Guide, Gap between theory and practice, Mentors
- Medical and Nursing Schools should offer learning experiences to future healthcare professionals for the provision of quality and patient-oriented care, which is scientifically documented, as members of a multidisciplinary team.
- Inclusion of courses in the programmes of study concerning the development of "soft" skills, such as team spirit, leadership, communication, cooperation/teamwork and risk management.

3.2.2 Training

- Carrying out of educational programmes in the workplace about safety control and error reporting, e.g. implementation of workshops, scenario-based practical training etc.

- Periodic evaluation, update and upgrade of the knowledge and skills of healthcare professionals regarding patient safety.

3.2.3 Research

- Increase of research activities, which should be included in the system of evaluation and advancement of healthcare professionals
- Creation of multidisciplinary researchers teams, which will determine the cause of errors and will contribute to the development of new knowledge and good prevention practices
- Funding of research programmes for the development and evaluation of new approaches in the training of healthcare professionals aiming to decrease errors and focus on patient safety
- Research programmes assessing the impact of new technologies in healthcare (robotics – telemedicine) and that include the impact of these tools to the safety of patients.

3.3 Break-out Session 3 – Safety Culture

3.3.1 Contribution of Healthcare professionals

- State support and incentives in measures targeting the development and improvement of safety culture
- Encouraging healthcare professionals and patients to report errors and oversights without any feelings of insecurity and fear
- Cooperation with all interested parties/bodies involved in the issue of patient safety
- Development of a sense of team spirit and effective communication and support
- Psychological support of healthcare professionals
- Development of a central platform containing examples of errors and good practices.

3.3.2 Training and Continuous Improvement

- Implementation of information and encouragement measures so that healthcare professionals and patients understand the reasons why it is necessary to report mistakes, errors, incidents etc.
- Provision of support to all personnel involved
- Implementation of an effective system of documentation of mistakes, errors, incidents etc. aiming to explore and put in place corrective actions

- Analysis and monitoring of documented information and data aimed at continuously improving healthcare services
- Cooperation with other stakeholders with the aim of adopting measures that promote and enhance safety culture
- Implementation of measures aimed at the shift from knowledge to learning
- Inclusion of patients, families and organised patients groups with the aim of patient-oriented healthcare
- Continuous assessment of the effectiveness and efficiency of measures for the reinforcement of safety culture.

3.4 Break-out Session 4 – Specific areas and activities: Primary healthcare, medication, operation, infections control, specialists' issues e.g. dentists, physiotherapists, radiologists, pharmacists etc.

3.4.1 Horizontal Recommendations

- Structured cooperation between health professionals – Establishing a team
- Definition of common objectives and communication of these objectives to the patient (and his/her family) as well as to the health professionals
- Control mechanisms concerning patient safety issues
- Effective communication between patient and health professional (inclusion of the patient & informed consent)
- Creation of rehabilitation centres to address existing needs
- Adoption of best practices at a national level concerning patient safety
- Recording, implementation and regular update of protocols and quality control procedures
- Continuous training of health professionals both on a general level and in specialised areas
- Encouragement of health professionals and patients to report errors and oversights and to provide feedback aiming to achieve continuous improvement
- Implementation of an effective system for documentation and collected data analysis
- Holistic handling of the patient
- Interconnection of primary and secondary healthcare.

3.4.2 Vertical Recommendations

- Hospital infection control – Creation of a reporting centre
- Assignment of clinical pharmacists to hospitals (at a ward level)

- Creation of a medication committee
- Electronic prescriptions system – Interactions between medicinal products etc.
- Referral protocols for radiology examinations
- Adherence to deadlines and effective monitoring of all measures.

Appendix 1 – Conference Programme

DAY 1
Friday, 25th January 2019

13:00 – 13:45 **REGISTRATION**

14:00 – 14:15 **WELCOME SPEECHES**

- Mr Vangelis Demosthenous, CEO, Kratis Training and Consulting Ltd
- Mr Nicos Christidis, Marketing Director for Cyprus, Medochemie
- Dr Petros Agathangelou, President of the Cyprus Medical Association
- Mr Demetris Syllouris, President of the Cypriot Parliament
- Mr Constantinos Ioannou, Minister of Health

PART 1 - Why Patient Safety?
(Coordinator: Dr Constantinos Phellas, Cyprus National Bioethics Committee, University of Nicosia)

14:15 *Opening address:*
Dr Constantinos Phellas, Chairman of the Cyprus National Bioethics Committee, Vice Rector for Faculty and Research, University of Nicosia

14:20 The scale and impact of human error and negligence in Healthcare
Dr Ioannis Markou, Hellenic Air Force, NHS

14:35 Reporting and learning system in a Public Hospital in Cyprus
Mrs Mary Kyriacou Georgiou, Head of Cyprus Quality Assurance Department in Healthcare

14:50 Q&A | Discussion

15:11 Coffee break

PART 2 - Best practices in Patient Safety
(Coordinator: Dr Christiana Kouta, Cyprus University of Technology)

15:40 *Opening address:*
Mr Ioannis Leontiou, President of Cyprus Nurses and Midwives Association

15:45 Measuring Patient Safety and Data Management
Prof Bryn Baxendale, Trent Simulation & Clinical Skills Centre, Nottingham University Hospitals NHS Trust

16:00 Success stories in Patient Safety - Manchester Bombing – Teamwork, Preparation and Planning
Dr Stephen Playfor, Paediatric Intensive Care Unit, Royal Manchester Children's Hospital

16:15 The Domino Effect of Medical Errors
Dr Samer Ellahham, Cleveland Clinic, Abu Dhabi

16:30 Incidents in the Healthcare Sector – Management, Investigation and Just Culture
Mr Vangelis Demosthenous, Kratis Training and Consulting Ltd

16:45 Q&A | Discussion

DAY 2
Saturday, 26th January 2019

PART 3 - Creating a Culture of Patient Safety
(Coordinator: Mr Panos Ergatoudes, Bank of Cyprus Oncology Centre)

09:00 *Opening address:*
Mr Marios Kouloumas, President of the Pancyprian Federation of Patients' Associations and Friends (ΠΟΣΠΦ)

09:05 *Opening address:*
Mrs Kikoula Kotsapa, Chairman of the Board of Directors of the Cyprus Certification Company (ΚΕΠ)

09:10 Appreciative Inquiry, Staff Morale and the Impact of Patient Safety
Dr Constantinos Kanaris, University Hospital North Midlands

09:25 Importance of Training and CRM simulation training in Patient Safety
Prof Bryn Baxendale, Trent Simulation & Clinical Skills Centre, Nottingham University Hospitals NHS Trust

09:40 Patient Safety at the bedside -Introduction of Care Bundles
Mrs Suzanne Dunne, Our Lady's Children's Hospital Crumlin, Dublin, Ireland

09:55 Safety culture, examples of implementation of patient safety practices
Dr Mina Ntantana, ICU Papageorgiou Hospital, Greece

10:10 Q&A | Discussion

10:30 Coffee break

PART 4 - Legal Issues
(Coordinator: Mr Yiannos Georgiades, Georgiades & Associates LLC)

11:00 *Opening address:*
Mr Theodoros Ioannides, President of the Cyprus Bar Association

11:05 Lessons learned from court cases in Cyprus
Mr Theodoros Ioannides, President of the Cyprus Bar Association

11:20 Good practices for the prevention and management of legal measures in healthcare
Mr Nikolaos Dialynas, Law offices Dialynas A. Nikolaos, Athens

11:35 Strategies to reduce clinical negligence claims (for lawyers and healthcare professionals)
Dr Stephen Playfor, Paediatric Intensive Care Unit

11:50 Q&A | Discussion

PARALLEL BREAK-OUT SESSIONS - Leading to suggestions for a 'Cyprus National Plan for Patient Safety'

12:00 – 13:15

Break-out Session 1:
Legislative and Regulatory Framework, Policies, Procedures, Instructions – Recommendations for Cyprus
Kratis plus a panel of stakeholders

Break-out Session 2:
Academic Education, Training, Research – Recommendations for Cyprus
Kratis plus a panel of stakeholders

Break-out Session 3:
Safety Culture – Recommendations for Cyprus
Kratis plus a panel of stakeholders

Break-out Session 4:
Specific areas and activities – Recommendations for Cyprus

Primary healthcare, medication, operation, infections control, specialists' issues e.g. dentists, physiotherapists, radiologists, pharmacists etc.
Kratis plus a panel of stakeholders

13:15 Lunch break

CLOSING

14:00 Presentation by the Rapporteurs of the 4 Break-out sessions (20 minutes)
14:20 Closing Remarks
14:30 End of the conference

Appendix 2 – Members of Break-out Sessions Committees

Session	Members of the Panels
Session 1: **General Regulations**	1. Mrs Mary Kyriacou Georgiou - Rapporteur, Head of Cyprus Quality Assurance Department in Healthcare 2. Mrs Elena Demosthenous, Standards Officer CYS 3. Mrs Aliki Agrotou, Lawyer, Cyprus Bar Association 4. Mr Yiannos Georgiades, Lawyer, Cyprus Bar Association 5. Mrs Elli Christodoulidou, Kratis
Session 2: **Education, Training and Research**	1. Dr Evanthia Georgiou - Rapporteur, Nursing Officer A', Education Department, Educational Programmes Management Team (ΟΔΕΠ) 2. Dr Elena Gabriel, Senior Nursing Officer, Core of Learning, Nursing Services Directorate 3. Dr Paola Nicolaidou, Medical School of the University of Nicosia 4. Mr Panayiotis Kouis 5. Mrs Vera Grigora, Kratis
Session 3: **Safety Culture**	1. Dr Melia Charalambous - Rapporteur, Senior Nursing Officer, Educational Programmes Management Team, Learning Sector 2. Dr Mariza Hadjicharalambous, Clinical Psychologist 3. Dr Androula Eleftheriou, Executive Director of Thalassemia International Federation 4. Dr Riana Constantinou, Cyprus Ambulance Service 5. Mr Panos Ergatoudes, Executive Director of the Bank of Cyprus Oncology Centre 6. Dr Stella Petronda, Cyprus Psychologists Association
Session 4: **Specific Initiatives**	1. Dr Persefoni Lambrou – Rapporteur, Dentist 2. Mrs Despo Constantinou, Senior Nursing Officer, Infections Control Nurse at the Nicosia General Hospital 3. Mrs Stavroula Kitiri, Head of Pharmacy Department, Bank of Cyprus Oncology Centre 4. Dr Prodromos Kaplanis, Senior Medical Physics Expert, Ministry of Health 5. Mrs Iris Roussou, Physiotherapist 6. Mr Vassos Lappa, Kratis

Appendix 3 – Speakers' CVs

SPEAKERS

Dr Ioannis Markou (MD)
Consultant Neurologist-Head of Department at Hellenic Air Force (HAF)
Consultant Neurologist at Hellenic Air Force and at Cumbria, Partnership NHS Foundation Trust. Long activity in human factors and accident investigations. He is assigned to the Health Division as Head of the Department responsible for the preparation of health support plans, for aviation medicine and for cooperation with NATO. He has been trained on air accident investigation in terms of human factor. Until recently he was a professor of aviation medicine at the Icarus School. Since 2008 he has been on the list of experts of the Athens and Piraeus Court of First Instance, which has resulted in a significant number of medical error assumptions.

Mary Kyriacou Georgiou (Bsc,Msc, Critical Care Nursing,APN)
Head of Quality Assurance Department Nicosia General Hospital
She is the President of the Cyprus Society for Quality in Health Care. She is a PhD candidate in Quality Assurance System of Health care. MSc in Advance Critical Care and Emergency care (Advance Clinical Practitioner). She holds a Post graduate diploma in Critical Care and Emergency care. She is a ATCN Instructor (Advance Trauma Care of Nurses). She is also Chief of the Pressure Ulcer Committee of Nicosia General Hospital and Editor of the translator team in Greek of the Quick Reference Guide of EPUAP. Mrs Kyriacou Georgiou is also instructor and trainer in Wound Management courses of the Hospital and Ministry of Health.

Prof Bryn Baxendale
Director, Trent Simulation & Clinical Skills Centre, Nottingham University Hospitals NHS Trust
He was appointed as a consultant anesthetist at NUH in 1998 and currently has clinical responsibilities related primarily to vascular and emergency surgical services at QMC. He is an honorary professor by the School of Psychology at the University of Nottingham. He has been President of the Association of Simulated Practice in Healthcare since 2009, which is the national learned body in relation to the use of simulation and related innovative learning technologies to professional education and training, workforce development, and quality and patient safety improvement. In 2012 Bryn joined the national strategy board for Technology Enhanced Learning led by Health Education England and the Higher Education Academy.

Dr Stephen Playfor MBBS, DCH, MRCP, MRCPCH, DM, FFICM
Royal Manchester Children's Hospital
Dr Playfor trained at Charing Cross and Westminster Medical School, University of London, and qualified in 1991. As part of his PICU training he worked in Toronto and Melbourne. Dr Playfor has worked at RMCH since 2002 where he is the Clinical Manager for PICU. He has a particular interest in intravenous fluid therapy and in particular the use of balanced intravenous fluids for children. Dr Playfor takes the lead for medico-legal issues within PICU and is working with the UK Paediatric Intensive Care Society and NHS England on developing a national Paediatric Major Incident Network.

Dr Samer Ellahham (MD,CPHQ, FACMQ, EFQM,FAHA,FACC,FACP)
Innovator,Chair,Middle East, Patient Safety Movement, Cardiovascular Consultant,Cleveland Clinic, Blockchain Healthcare
Dr Ellaham is Middle East Representative, JCI Standards Advisory Panel, Middle East Chairperson, Member of Patient Safety Movement, Certified Master Black Belt Six Sigma, Certified Lean Healthcare Practitioner, Cardiology Consultant, Heart and Vascular Institute Cleveland Clinic Abu Dhabi Cleveland Clinic Caregiver.

Vangelis Demosthenous, MSc
Managing Director, Kratis Training and Consulting
He has a Master's degree in Safety Management. He worked for many years, as a licensed aircraft engineer with parallel activity as a trainer for safety and human factors. Since 2005 he manages Kratis with hands-on activity in delivering training, consulting and assisting organisations in over 33 counties on safety, human factors, incident investigation, safety management etc. He is a member of the European Union (EASA) Aviation Safety and Human Factors committees. He served in the executive boards of Aircraft Engineers International and Flight Safety Foundation (Med). He contributed in EU-funded research projects on safety and human factors.

Dr Constantinos Kanaris (BSc (Hons), MBChB, MRCPCH, PhD.)
Consultant in Paediatric Intensive Care, Royal Manchester Children's Hospital
Consultant in Paediatric Intensive Care at UHNM and NWTS and an Honorary Lecturer at Keele University Medical School. He holds Undergraduate, Postgraduate and PhD degrees from the University of Manchester (PPP Healthcare Scholarship alumnus). He trained at Royal Manchester Children's Hospital and Alder Hey Hospital, Liverpool. He was the Royal College of Paediatrics and Child Health's NW trainee representative; is a member of Q-community and an advocate in learning via appreciative-inquiry and patient safety via quality improvement and innovation. His Interests include paediatric resuscitation, difficult airway management, paediatric palliative care, free on-line medical education and virtual reality simulation (Twitter @DrKanaris).

Suzanne Dunne
Clinical Nurse Manager III in Quality, Licensing & Standards Our Lady's Children's Hospital Crumlin, Dublin, Ireland
She has a very keen interest in improving patient safety and have recently completed the first Irish Master's Degree programme in Human Factors in Patient Safety from the Royal College Surgeons Ireland (RCSI). She also hold a Master's Degree in Healthcare Management (RCSI) and a Post Graduate Certificate in Anaesthetic/Recovery Nursing, from the College of New South Wales, Australia. Previous roles include Patient Safety & Clinical Risk Advisor (OLCHC) and Quality & Risk Manager.

Mina Ntantana (MBA, PhD)
ICU Nurse Director at PAPAGEORGIOU GENERAL HOSPITAL MBA, PhD
An experienced MBA Director with a demonstrated history of working in the hospital & health care industry. Skilled in Clinical Research, Medical Education, Nursing Education, Life Support, and Medicine. Holds a Master of Business Administration (M.B.A.) degree focused in Health Services

Administration from Panepistimion Makedonias and a PhD from the University of Ioannina.

Theodoros Ioannides
President, Cyprus Bar Association
He represents the Cyprus Bar Association in Council of Bars and Law Societies of Europe (CCE), International Bar Association (IBA), Union of Balkan Bar Associations, Union of Balkan Law. Mr Ioannides presides at the General Prosecutor of the Disciplinary Lawyers Council and represents the Cyprus Bar Association in the Legal Council and the Lawyers Pension Fund.

Nikolaos Dialynas, PhD LMU (Luedwig- Maximilian Universitaet)
Lawyer, Law offices Dialynas A. Nikolaos, Athens Greece
Graduate of the German School of Thessaloniki, graduate of the Law School of Thessaloniki with a doctoral dissertation on the minor child and his legal representative as well as an assistant in Greek, German and French civil law. His doctoral dissertation took place in Germany at the Luedwig-Maximilian Universitaet in Munich. He is the first to introduce and develop the medical law sector in Greece with 25 years of experience on the subject with a number of court cases.

COORDINATORS

Constantinos N. Phellas, PhD
Vice Rector for Faculty and Research, University of Nicosia. Chairman of the Cyprus National Bioethics Committee
He received an MSc in Management Science and Operational Research from the University of Warwick, UK and an MSc in Advanced Social Research Methods and Statistics from City University London, UK. In 1998, he obtained his PhD in Sociology from the University of Essex, UK. He serves as an evaluator for European Funding Agencies and holds official European and Governmental appointments; among others, he is the Chairman of the Cyprus National Bioethics Committee, a member of the Bureau of the Council of Europe's Bioethics Committee (DH-BIO), a member of the Cyprus National Transplant Board, a member of the National Medical Assisted Reproductive Board.

Dr Christiana Kouta, PhD, Msc, Bsc, DipN, RN
Associate Professor, Department of Nursing School of Health Sciences, Cyprus University of Technology
She is the Head of the Master in Advance Nursing and Community Health and Care and she is teaching at graduate and undergraduate level. Her research combines community and transcultural health in relation to culture and gender. She is currently leading an EU funded project IENE 8, with the use of an on line Knowledge Hub for health professionals aiming in empowering migrant and refugee families on parenting skills. She is a member of the Board of Directors of the Cyprus University of Technology and the Secretary of the European Transcultural Nurses Association (ETNA) since 2013.

Panos Ergatoudes
Chief Executive Officer, Bank of Cyprus Oncology Centre
He holds a masters degree in Hospital Management from the University of Leeds and an MBA from the Cyprus International Institute for Management. He worked for 11 years at the position of Chief Operating Officer at the American Medical Center/American Heart Institute and since September

2016, is the Chief Executive Officer of the Bank of Cyprus Oncology Center. He has special interest in strategy development, project management, developing new services and culture change.

Yiannos G Georgiades
Managing Partner, Georgiades &Associates LLC, Advocates & Legal Consultants
He has over 25 years' experience and he is a member of the Athens Bar Association, Cyprus Bar Association, Bar of England and Wales (Honourable Society of Gray's Inn), the International Bar Association, the American Bar Association, the Society for Computers and Law, the International Technology Law Association, President of the Cyprus Branch of the European Court of Arbitration, executive member of the Court and an online mediator for commercial disputes for the Chamber of Commerce of Milan and is the Vice-President of AEA International Lawyers Network.