World Patient Safety Day 2024

WHO Global Consultation

Improving diagnostic safety and implementing the Global Patient Safety Action Plan 2021-2030

10th – 12th September 2024
Geneva, Switzerland

World Health Organization

World Patient Safety Day 17 September 2024

WPSD 2024 Global Consultation
Improving diagnostic safety
and implementing Global Patient Safety Action Plan 2021-2030

Housekeeping announcements

General

- 2.5 days hybrid consultation/09:00 CEST 10 Sep - 12:30 CEST 12 Sep
- 7 sessions/mix of presentations, panel discussions, expert dialogues, stories and sharing of experiences
- The official language of the consultation is English/No interpretation will be available
- Please, use the headphones for videos
- Recording will be available on official WHO events webpage
- For further questions, please contact: patientsafety@who.int

For virtual participants

- Connection platform is Zoom/Register here, and feel free to share the link widely
- Participation is available for plenary sessions only/no live stream during breakout groups

For in-person participation

- Venue ILO, Salle E (main venue), Salle A and C (breakout groups)
- Coffee-breaks will provided/No lunch will be provided
- WIFI connection is – please select ILO public and no password required
- Use microphones and introduce yourself before the intervention

Opening remarks

Dr Rudi EGGERS
Director
Integrated Health Services
WHO Headquarters
Switzerland

World Health Organization

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Objectives of the consultation Introduction to the WPSD 2024 theme

Dr Irina PAPIEVA
Technical Officer/Lead a. i.
Patient Safety Flagship,
Integrated Health Services
WHO Headquarters
Switzerland

World Health Organization

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Address by the WHO Director-General

Dr Tedros Adhanom GHEBREYESUS
WHO Director-General
WHO Headquarters
Switzerland

World Health Organization

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World Health
Organization

Welcome remarks

By Co-chair of the WHO World Patient Safety Day 2024 Steering Committee

Professor Yasuhiro SUZUKI

Advisor for International Affairs

Ministry of Health, Labour and Welfare

Japan

World Health Organization

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Welcome remarks

By Co-chair of the WHO World Patient Safety Day 2024 Steering Committee

Dr Deusdedit MUBANGIZI

Director, Health Products Policy and Standards

WHO Headquarters

World Health Organization

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WHO Campaign video

World Health Organization

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Unlocking safer care: the imperative of diagnostic safety

Sir Liam DONALDSON
WHO Envoy for
Patient Safety
WHO headquarters

World Health Organization

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SLIDO: What do we know and what do we still have to learn about diagnostic safety?

World Health Organization

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Two sides, one truth: experiences of diagnostic safety

Terence Vanginkel
WILDE
Patient representative
Canada

Aline Cristina
PEDROSO
Registered Nurse
Brazil

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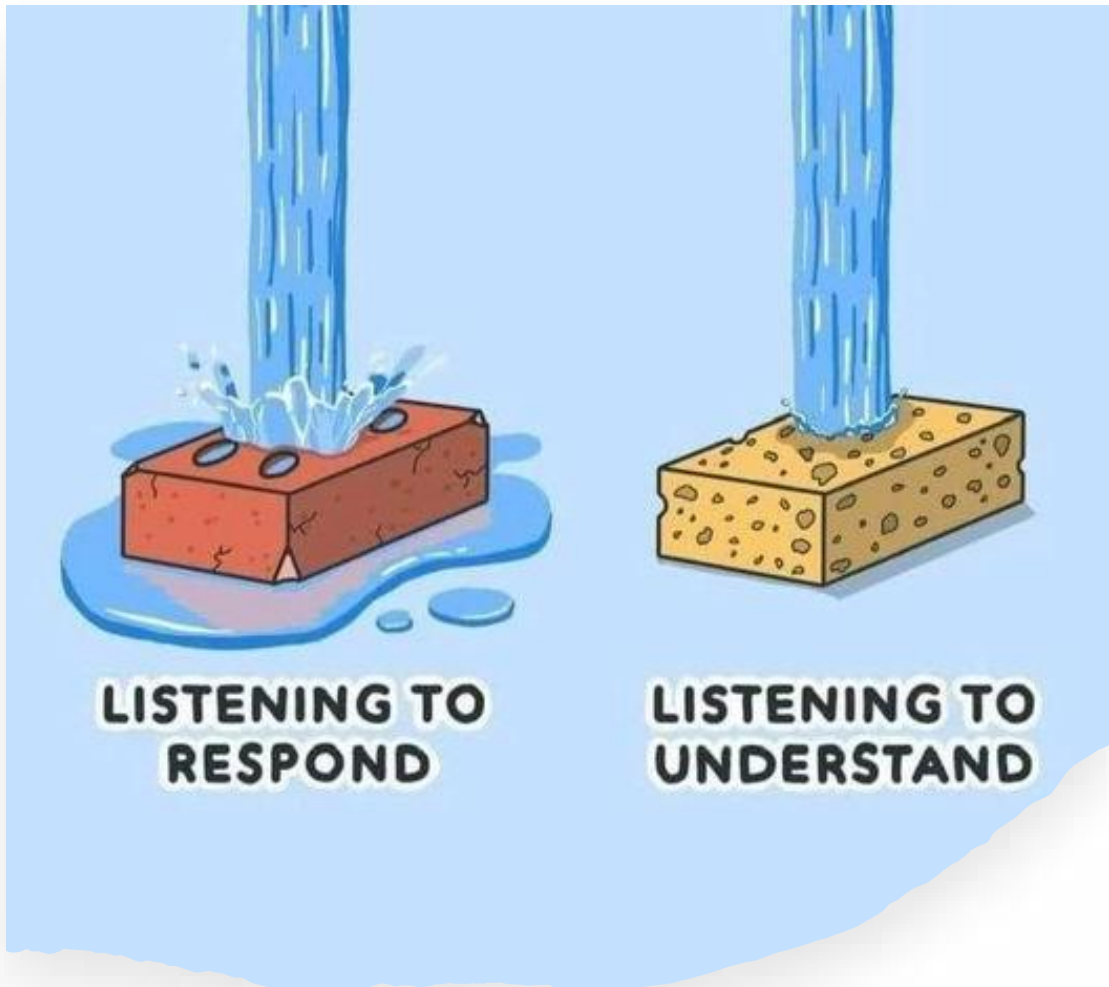
LISTENING TO RESPOND
LISTENING TO UNDERSTAND

Turning to Stone
SL Wilde

Lots of Delays in Diagnosis and Diagnostic Harm is Caused by Health Data Challenges

Patient Safety is not just the Absence of Harm, but the Presence of Safety

Panel discussion 1
Understanding the landscape of diagnostic safety

Moderator
Sir Liam DONALDSON
WHO Envoy for Patient Safety
WHO HQ
Switzerland

Panellist
Ms Helen HASKELL
President, Mothers Against Medical Error
USA

Panellist
Dr Gustavo Faissol Janot de MATOS
Intensive care physician
Brazil

Panellist
Prof Carmel MORAN
Chair of the World Federation of Ultrasound for medicine and biology Safety Committee
Switzerland

Panellist
Dr Malathi ARSHANAPALAI
Group Quality Director and Group Academic Director, Aster DM Healthcare, UAE

Panellist
Dr Henrietta HUGHES
Patient Safety Commissioner
United Kingdom

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Diagnostic safety; state of the science 2024

Prof. Hardeep SINGH

Co-Chief, Health Policy, Quality and Informatics Program,

Michael E. De Bakey Veterans Affairs Medical Center and Baylor College of Medicine, USA

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Diagnostic Safety: Basic Concepts, Application to Practice and How to Make Change

Hardeep Singh, MD, MPH

CENTER FOR INNOVATIONS IN QUALITY, EFFECTIVENESS & SAFETY (IQUEST)

MICHAEL E. DEBAKEY VA MEDICAL CENTER

BAYLOR COLLEGE OF MEDICINE

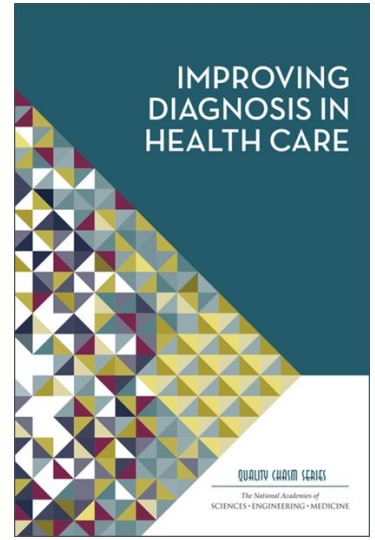
TWITTER: @HardeepSinghMD

Two Decades of Multidisciplinary Work

Improving Diagnosis in Health Care — The Next Imperative for Patient Safety

Hardeep Singh, M.D., M.P.H., and Mark L. Graber, M.D.

The NEW ENGLAND JOURNAL of MEDICINE



Physician Cognition

Systems (e.g., EHR)

5% of US Veterans (1 Million Veterans) may experience diagnostic errors every year.

Patient Experiences a Health Problem

Patient Engages with Health Care System

INFORMATION INTEGRATION & INTERPRETATION

Has sufficient information been collected?

Clinical History and Interview

Physical Exam

Referral and Consultation

Diagnostic Testing

INFORMATION GATHERING

WORKING DIAGNOSIS

Communication of the Diagnosis

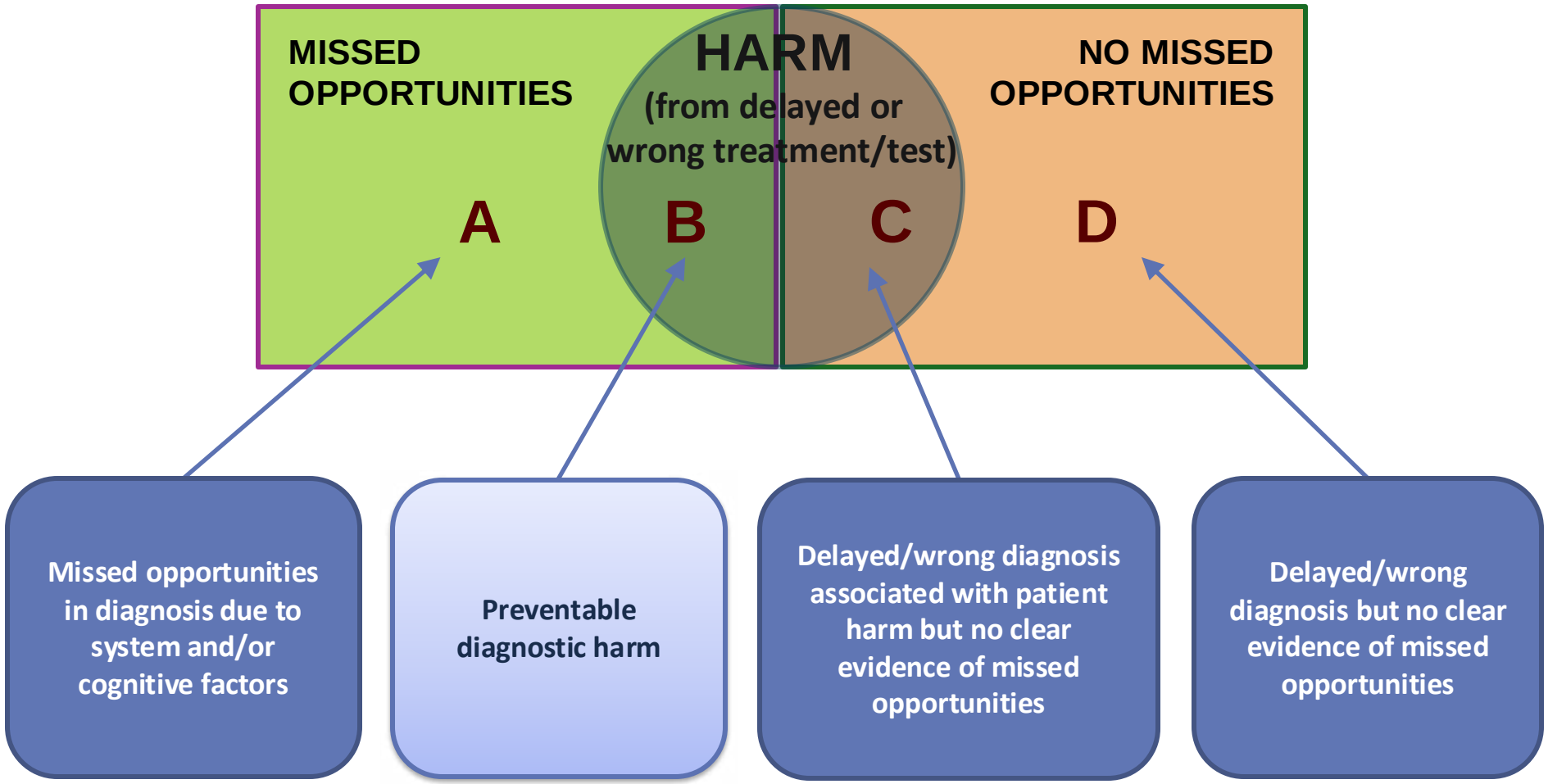
Treatment

Outcomes

TIME

Adapted from National Academy of Medicine Report, Improving Diagnosis in Health Care, 2015.

Defining Preventable Diagnostic Harm



Adapted from Singh, Jt Comm J Qual Pat Saf 2014

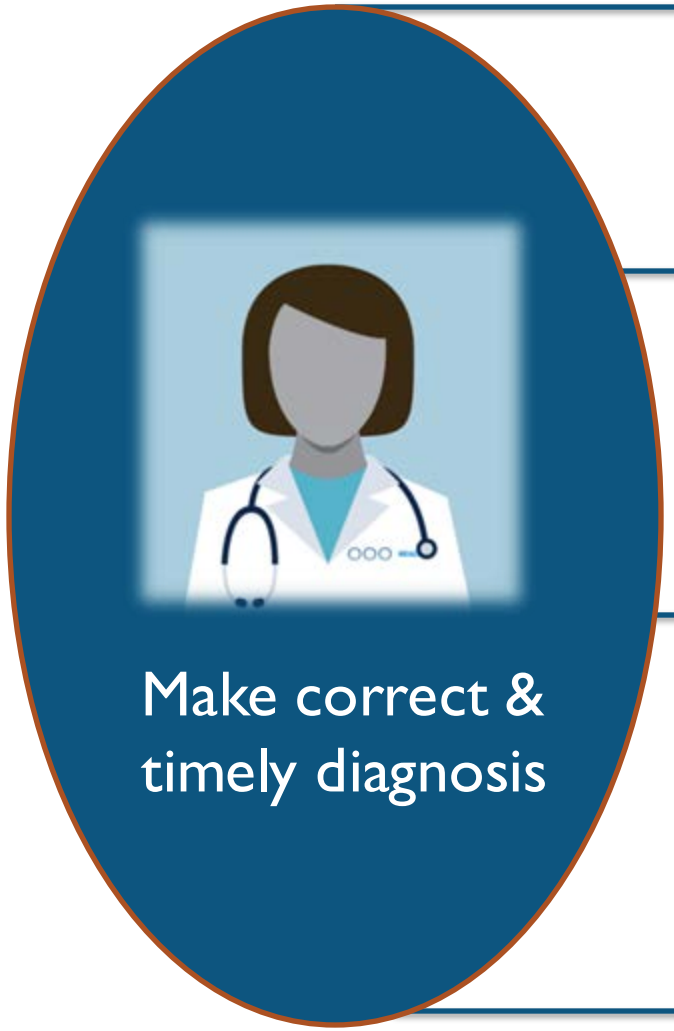
Defining Diagnostic Safety Event

- Agency for Healthcare Research and Quality (AHRQ) Definition - criteria is met if one or both of the following occurred, whether or not the patient was harmed:
- 1) **Delayed, Wrong, or Missed Diagnosis**: There were one or more missed opportunities to pursue or identify an accurate and timely diagnosis (or other explanation) of the patient's health problem(s) based on the information that existed at the time.
- 2) **Diagnosis Not Communicated to Patient**: An accurate diagnosis (or other explanation) of the patient's health problem(s) was available, but it was not communicated to the patient (includes patient's representative or family as applicable).

Defining Diagnostic Safety: Five Attributes

Accuracy = diagnosis is correct
Timeliness =absence of significant preventable delays
Efficiency = appropriate/streamlined use of resources to make diagnosis
Patient-centered= maximizing patient experiences and ensuring the explanation of the health problem is communicated to and understood by the patient
Equitable = absence of preventable unwarranted variations in diagnostic processes among population groups that are socially, economically, demographically, or geographically disadvantaged

Defining Diagnostic Excellence



- Use fewest resources
- Maximize patient experiences
- Manage and communicate uncertainty to patients
- Tolerates watchful waiting when unfocused treatment may be harmful

Meyer AND, Singh H. The Path to Diagnostic Excellence Includes Feedback to Calibrate How Clinicians Think. *JAMA.* 2019;321(8):737–738

Themes from Research Studies

Common diseases missed

Missed opportunities to elicit or act upon key clinical findings (history/exam)

Involves nearly all diseases and multiple care settings

Singh et al JAMA IM 2012; Singh et al Arch IM 2009

Contributing Factors

Premature closure

Affective bias

Faulty synthesis

Overconfidence

Process failure

Unintended consequence of policy

Sample mix-up

Faulty data gathering

Failure to detect physical finding

Perception error

Misinterpretation of test

Wrong estimate of pretest probability

Inadequate follow-up

Failure to follow up abnormal test

Failed heuristic

Limited access

Communication failure

Knowledge deficit

Language barrier

Faulty triggering

Uninformed patient

Thanks to Karen Cosby, MD

Recommendations

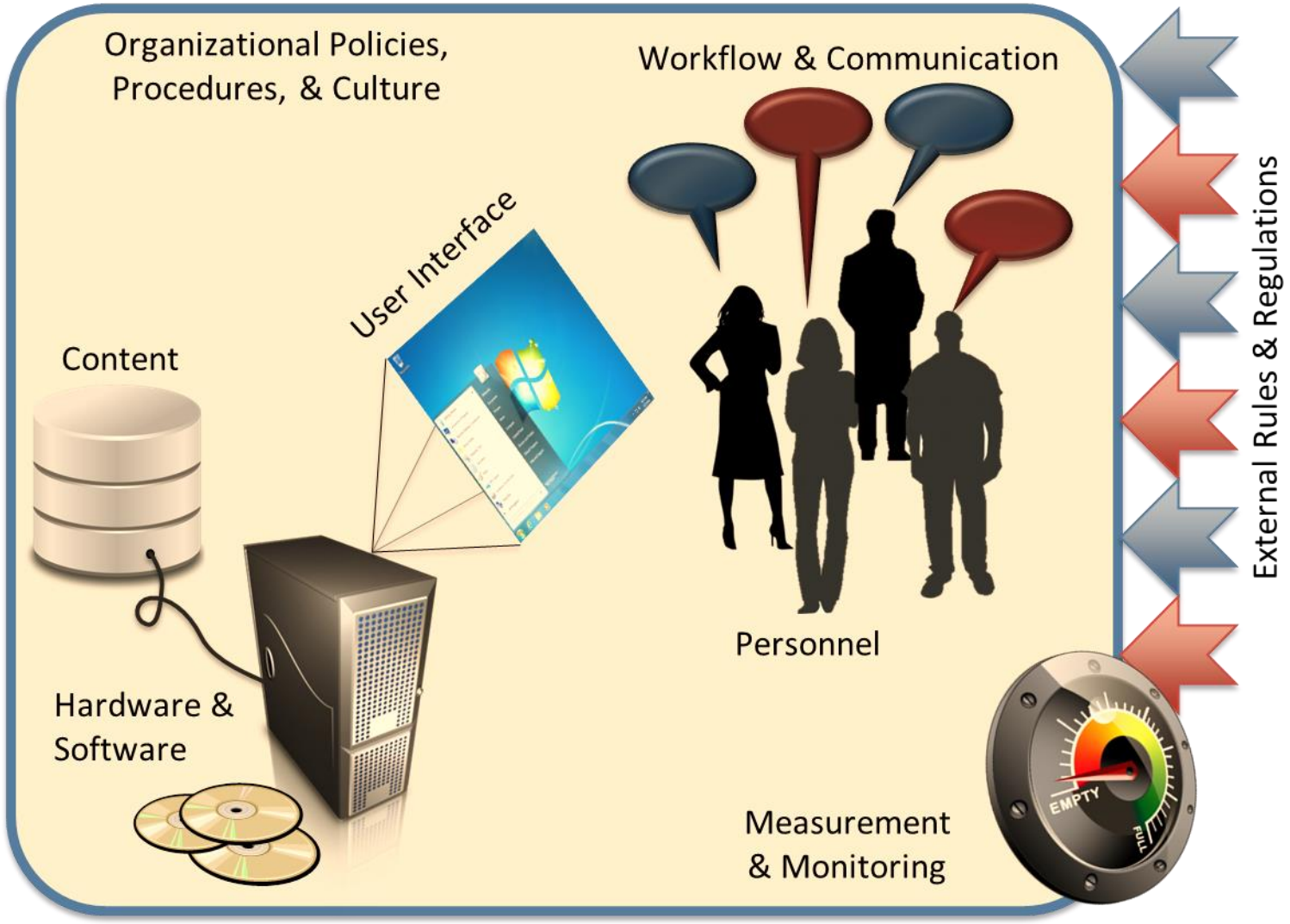
- More effective **teamwork** in the diagnostic process
- Enhance health care professional **education and training**
- Ensure **health information technologies** support patients and health care professionals
- Implement **approaches to identify, learn from, and reduce** diagnostic errors/near misses in clinical practice
- Establish a **work system and culture** that supports the diagnostic process and improvements
- Provide **dedicated funding for research** on the diagnostic process and diagnostic errors

Additional Progress

- Conferences and journal *Diagnosis*
- Several agencies now involved: AHRQ, CDC, Leapfrog, OECD and WHO
- Research being translated to patient care with new toolkits, guides and helpful resources
- Health care organization and systems more active in many countries

Some Major Gaps

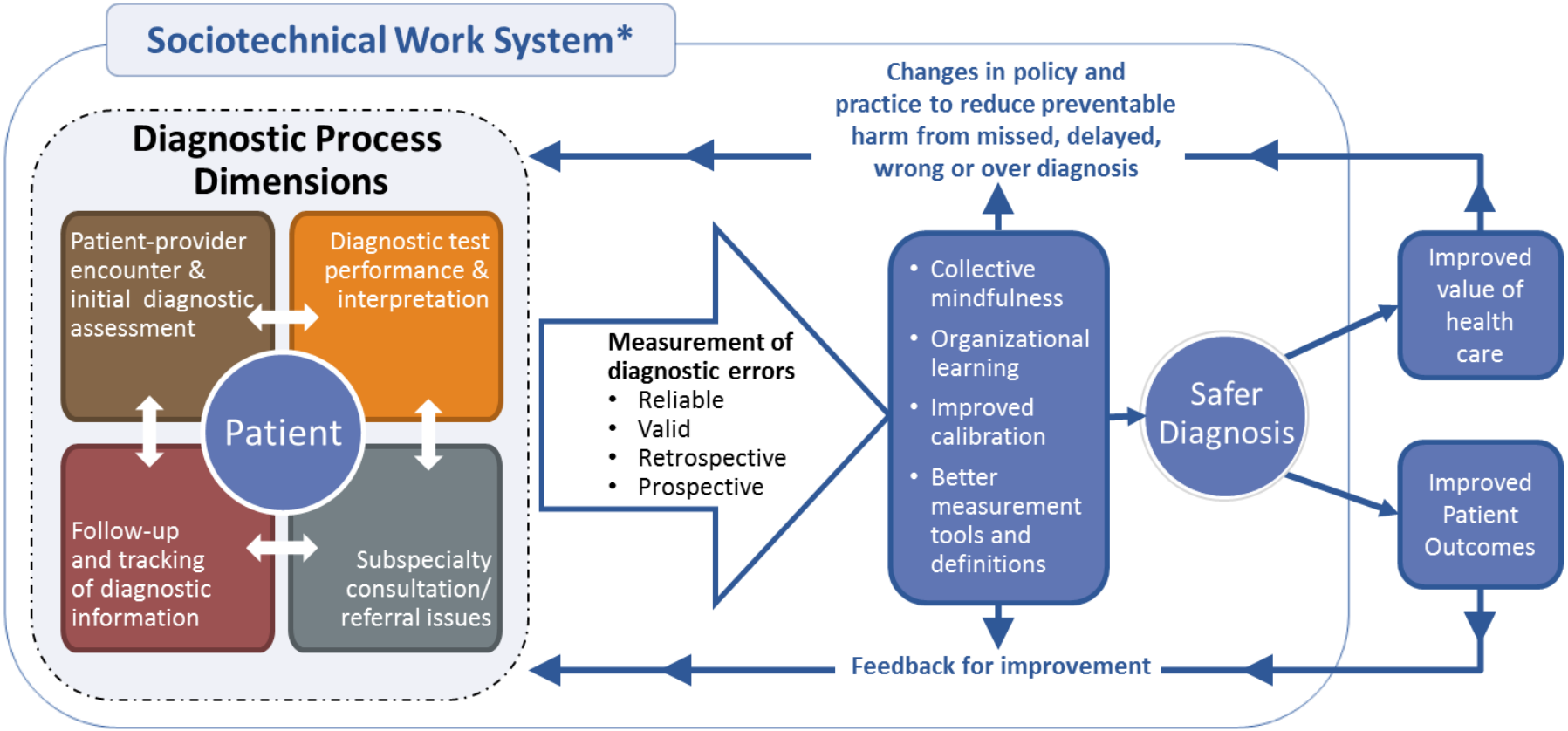
- A comprehensive appreciation of diagnostic safety in low- and middle-income countries
- Data from certain care settings
- Culture and psychological safety issues
- Data sources esp. patient and clinician sources
- Measurement for improvement and learning



Focus on Systems Approaches

Sittig, Singh, *Qual Saf Health Care. 2010 Oct; 19(Suppl 3): i68–i74.*

Safer Dx Framework for Measurement and Reduction of Diagnostic Errors



* Includes 8 technological and non-technological dimensions

Singh and Sittig, BMJ Qual Saf 2015

Creating Learning Health Systems

The Safer Dx Checklist

10 High-Priority Practices for Diagnostic Excellence

PREPARED BY:

Center for Innovation in Quality, Effectiveness, and Safety (IQuESt), Michael E. DeBakey Veterans Affairs Medical Center and Baylor College of Medicine, Houston, TX

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- Umair Mushtaq, MBBS, MS
- Umber Shahid, PhD, MPH

Geisinger, Danville, PA

- Divvy Kant Upadhyay, MD, MPH

Institute for Healthcare Improvement, Boston, MA

- Joellen Huebner, BA
- Patricia McGaffigan, RN, MS, CPPS

http://www.ihi.org/resources/Pages/Tools/safer-diagnostic-checklist.aspx

Patient

Toolkit for Engaging Patients To Improve Diagnostic Safety

Encourage patients to share their story with the **Be The Expert On You** note sheet

Build a collaborative environment using the **60 Seconds To Improve Diagnostic Safety** strategy

Clinician

Calibrate Dx: A Resource to Improve Diagnostic Decisions

A tool for clinicians to evaluate and improve their own diagnostic decision-making.

Specify the calibration task

Plan and Apply improvement strategies

Evaluate diagnostic performance

Reflect on the exercise and adjust as needed

Team

TeamSTEPPS® for Diagnosis Improvement

Module 1: Introduction

Module 2: Diagnostic Team Structure

Module 3: Communication

Module 4: Leadership

Module 5: Situation Monitoring

Module 6: Mutual Support

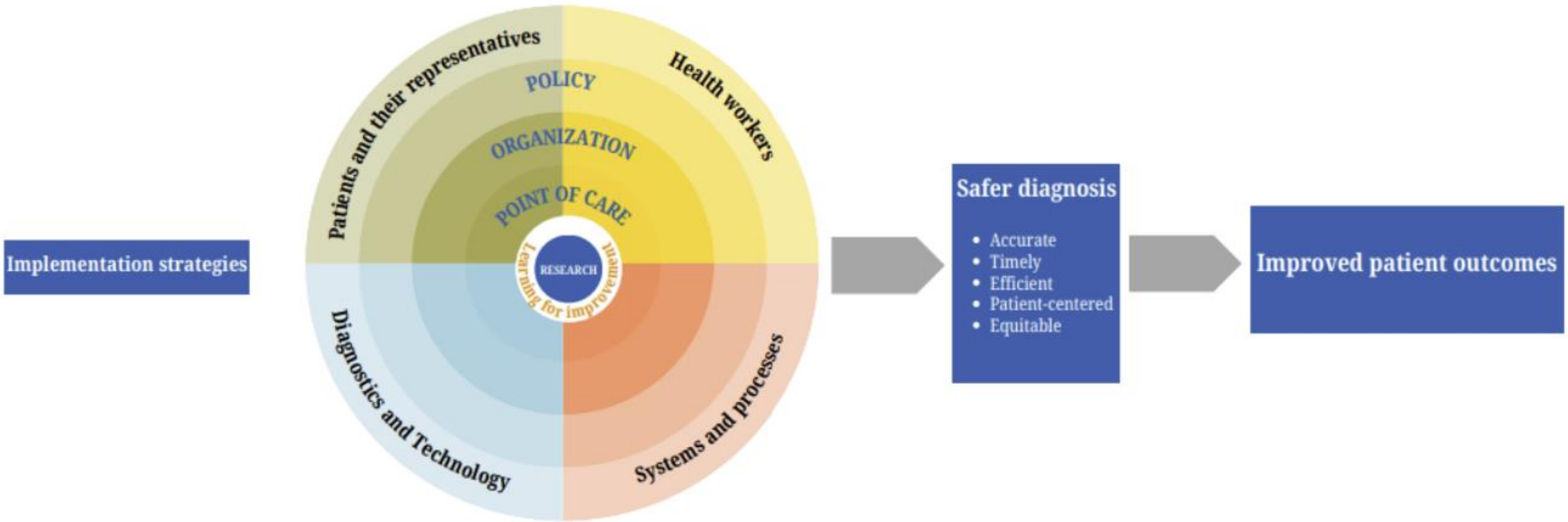
Module 7: Putting It All Together

Organization

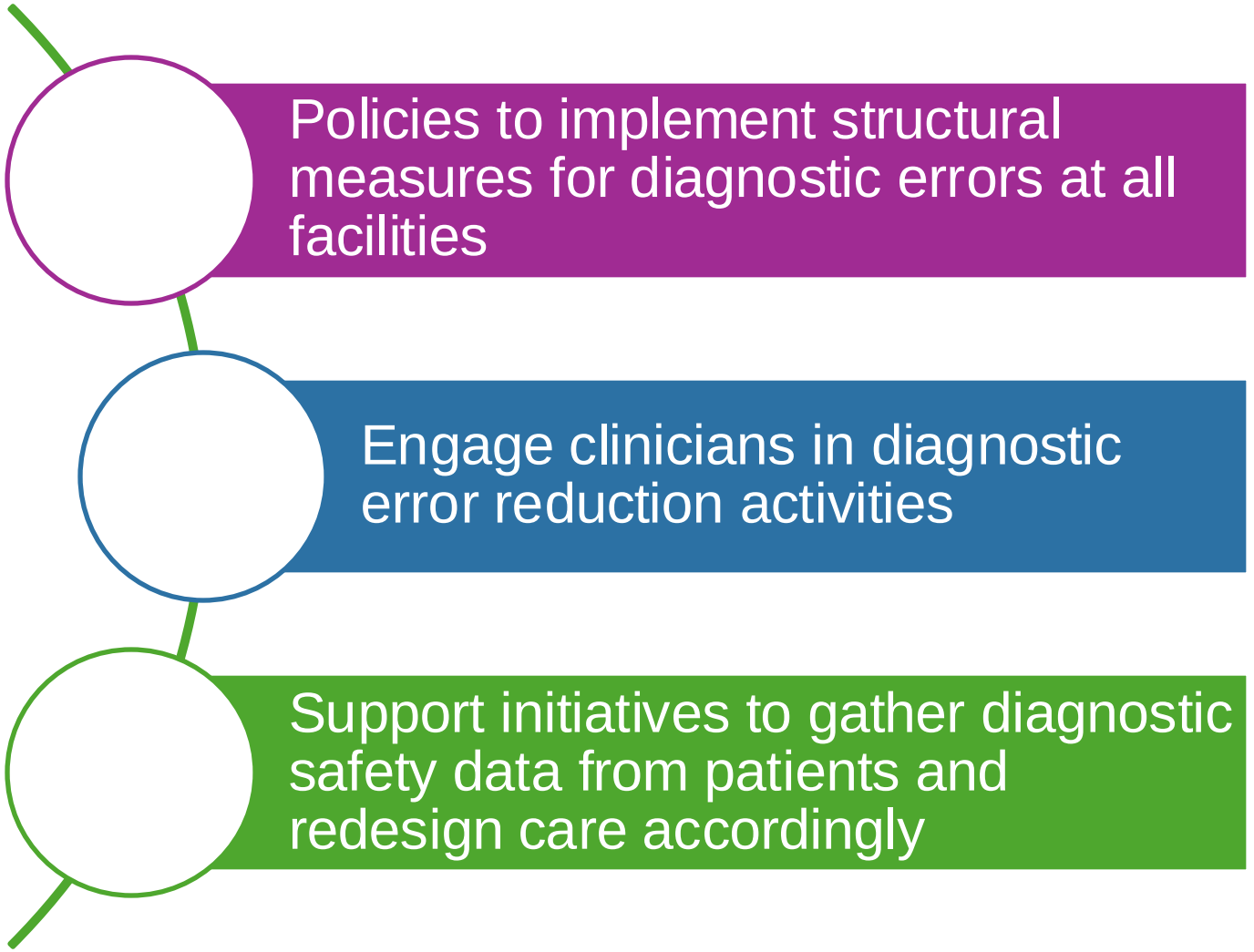
Measure Dx

Measure Dx helps healthcare organizations detect diagnostic safety events and learn from them to gain actionable insights for improvement.

Figure 1. Implementation model to improve diagnostic safety



Next Steps for Diagnostic Safety?



Thank You

- **Funding Agencies that make research possible:**
  - Department of Veterans Affairs
  - Agency for Healthcare Research and Quality
  - Gordon and Betty Moore Foundation
  - CanTest - CRUK
  - ONC for SAFER Guides

- **Our multidisciplinary team at the Center for Innovations in Quality, Effectiveness and Safety (IQuESt):**
  - Email: hardeeps@bcm.edu
  - Web: http://www.houston.hsrd.research.va.gov/bios/singh.asp and www.bcm.edu/saferdx
  - Twitter: @HardeepSinghMD

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Session 1
Diagnostic safety - a team effort

Chairperson

Dr Abdulelah ALHAWSAWI
Advisor
Saudi Patient Safety Centre
Saudi Arabia

Co-chairperson

Dr Tuija IKONEN
Finnish Centre for Client and Patient Safety
Helsinki, Finland

World Health Organization

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Misdiagnosis, me and AI: a story for our times

Ms Sue SHERIDAN
Founding member,
Patients for Patient Safety, US
USA

World Health Organization

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Patients Use AI

Sue Sheridan is hit with another medical error. This time, ChatGPT prevented the worst.

Patient safety legend Sue Sheridan had never touched AI. But then ...

DAVE DEBRONKART

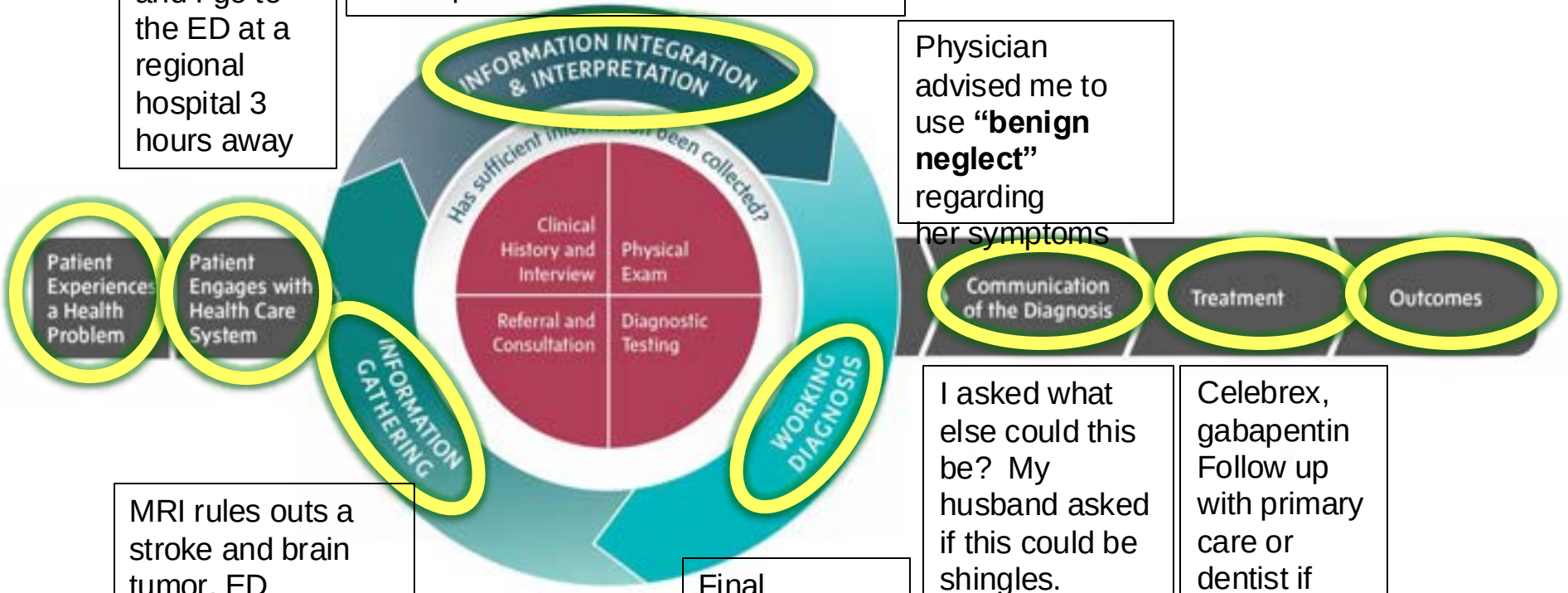
AUG 27, 2024

Sue's DX Journey - Day 1

After days of intermittent pain on the right side of my face, jaw, teeth, ear and scalp, my husband, a doctor, notes drooping on the right side of my face

My husband and I go to the ED at a regional hospital 3 hours away

Physician documents "she has no other deficits to suggest Bell's Palsy … so not placed on steroids or antivirals."



Physician advised me to use **"benign neglect"** regarding her symptoms

I returned home and experienced severe facial pain through the night. Facial droop persists

MRI rules outs a stroke and brain tumor. ED physician documents, "Chief complaint: R sided facial droop, pain on R side. Pt had recent dental work"

Final diagnoses:
- Facial Droop
- Unspecified headache

I asked what else could this be? My husband asked if this could be shingles. Response was, **"We don't diagnose in the ED"**

Celebrex, gabapentin Follow up with primary care or dentist if symptoms persist. (This was Friday at 17:00 hours)

SOURCE: National Academies of Sciences, Engineering, and Medicine. 2015. *Improving Diagnosis in Health Care*. Washington, DC: The National Academies Press.

Turning to ChatGPT:

A “second opinion” to support us in decision making

ChatGPT >

Facial droop, facial pain and dental work

Facial droop and facial pain after dental work could be related to several different causes. Here are a few possibilities:

3. **Bell's Palsy:** This condition causes sudden weakness or paralysis on one side of the face and can be triggered by stress or viral infections. Dental work, especially if it involves significant stress, might precipitate an episode.

Treatment Options

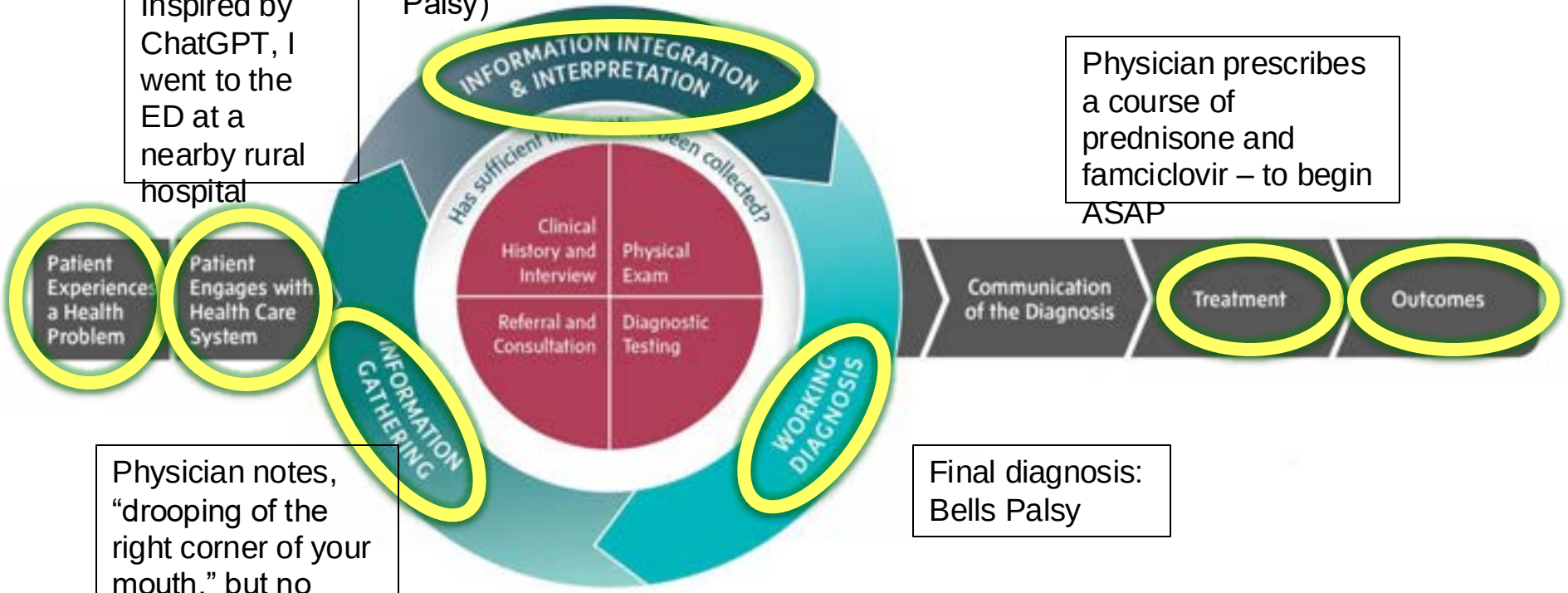
1. **Corticosteroids (e.g., Prednisone):**
   - The most effective treatment when started early.
   - Reduces inflammation around the facial nerve.
   - **Window:** Most effective if started within **72 hours** of symptom onset.
2. **Antiviral Medications (e.g., Acyclovir or Valacyclovir):**

Sue's Journey - Day 2

I continued to have facial droop, no other weakness, and severe intermittent pain in my face, jaw, teeth, ear and scalp

Inspired by ChatGPT, I went to the ED at a nearby rural hospital

Physician concludes, "You likely have facial nerve palsy (Bell's Palsy)"



Physician prescribes a course of prednisone and famciclovir – to begin ASAP

My pain subsides, facial droop persists

Physician notes, "drooping of the right corner of your mouth," but no other weakness.

Final diagnosis: Bells Palsy

SOURCE: National Academies of Sciences, Engineering, and Medicine. 2015. *Improving Diagnosis in Health Care*. Washington, DC: The National Academies Press.

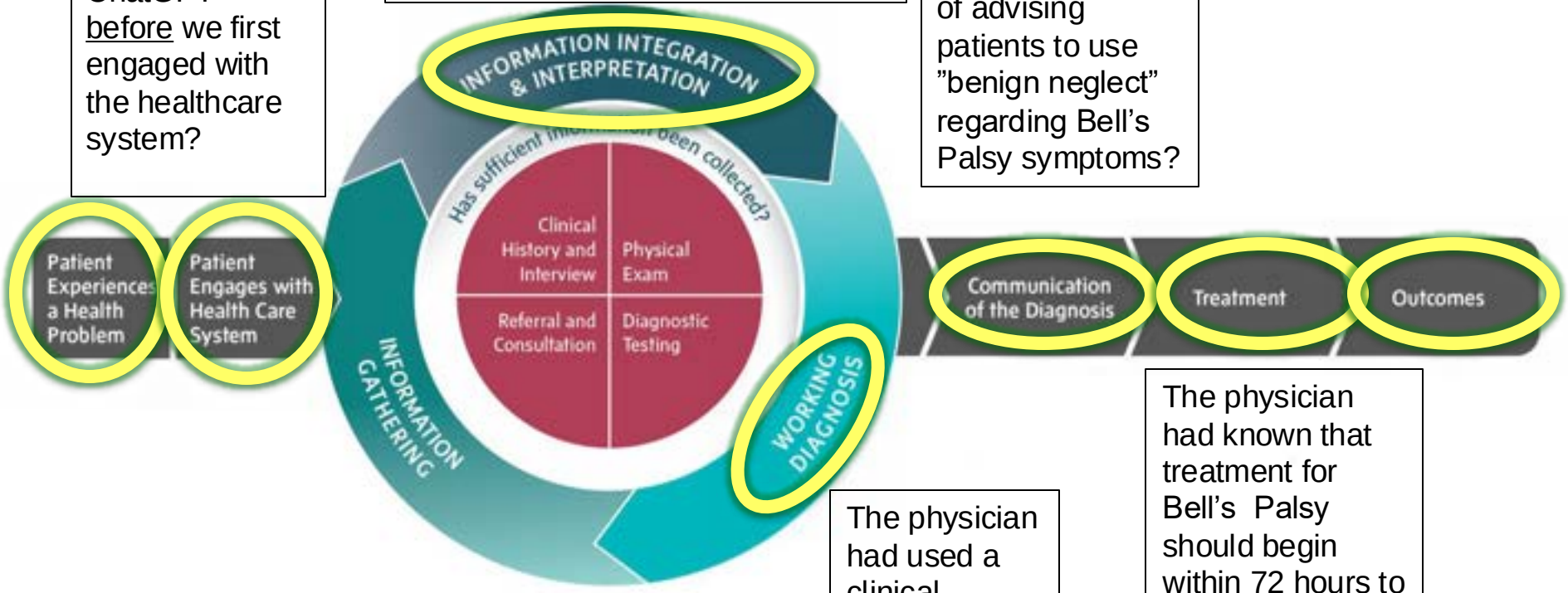
“What if……”

I had facial drooping and intermittent severe face, jaw, teeth, ear and scalp pain on right side with no other weakness

We had used ChatGPT before we first engaged with the healthcare system?

The physician had known the standard clinical guidelines for diagnosing Bell’s Palsy?

The physician had known the potential danger of advising patients to use ”benign neglect” regarding Bell’s Palsy symptoms?



The physician had used a clinical decision support tool powered by AI to reach a diagnosis?

The physician had known that treatment for Bell’s Palsy should begin within 72 hours to avoid devastating outcomes?

I would have been asked to share my patient experience and outcomes through PREMs and PROMs that asked questions about my diagnostic journey?

SOURCE: National Academies of Sciences, Engineering, and Medicine. 2015. *Improving Diagnosis in Health Care*. Washington, DC: The National Academies Press.

#PatientsUseAI

Patients are end users of AI

Medical work patients do with AI:

Patient administrative burden

Organizing records for action

Comprehension (records and literature)

Difficult diagnosis

Exploring knowledge & options

How can we leverage the promise of AI …..?

" To help patients - the largest workforce out there - help themselves responsibly?" Khang Nguyen, MD, Chief Transformation Officer at S. California Kaiser Permanente

To collaborate with clinicians to help them incorporate AI-based input from patients?

To ensure that diagnostic errors discovered by AI generate learnings for clinicians?

And build AI systems that align with patient rights and interests by engaging them in co-development and governance?

How can we change a culture …….

That dismisses and disrespects patients who use information….

"no slander intended to the family as i acknowledge their frustration during a medical crisis, but pts that "doctor shop" multiple different doctors across multiple hospitals during an acute disease flare are contributing to the epidemic of dx error."

To a culture that celebrates informed patients?

"As a seasoned general surgeon, I can say that there is nothing like being graced with an informed intelligent patient who advocates for themselves or their family members and friends."

My biggest “what if”

What if I had used “benign neglect” and hadn’t turned to AI?

How can we …….

Maximize the agency of patients to have the power and resources to fulfill their potential in getting an accurate and timely diagnosis?

Only then can patients help healthcare achieve its maximum potential.

Panel discussion 2
Enhancing diagnostic safety

Moderator
Dr Abdulelah ALHAWSAWI
Advisor
Saudi Patient Safety Centre
Saudi Arabia

Panellist
Dr W M Upuli S Wijemanne
Director, Healthcare Quality and safety
Ministry of Health, Sri Lanka

Panellist
Dr Ali ASERI
Director General
Saudi Patient Safety Center,
Saudi Arabia

Panellist
Dr Aidan FOWLER
National Director, Patient Safety
England
United Kingdom

Panellist
Dr Lydia OKUTOYI
Director of Healthcare Quality
Kenyatta National Hospital
Kenya

Panellist
Dr Mark L. GRABER
Professor Emeritus of Medicine at Stony Brook University
New York
USA

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The implementation model for improving diagnostic safety

Dr Irina PAPIEVA
Technical Officer/Lead a. i.
Patient Safety Flagship,
Integrated Health Services
WHO Headquarters
Geneva, Switzerland

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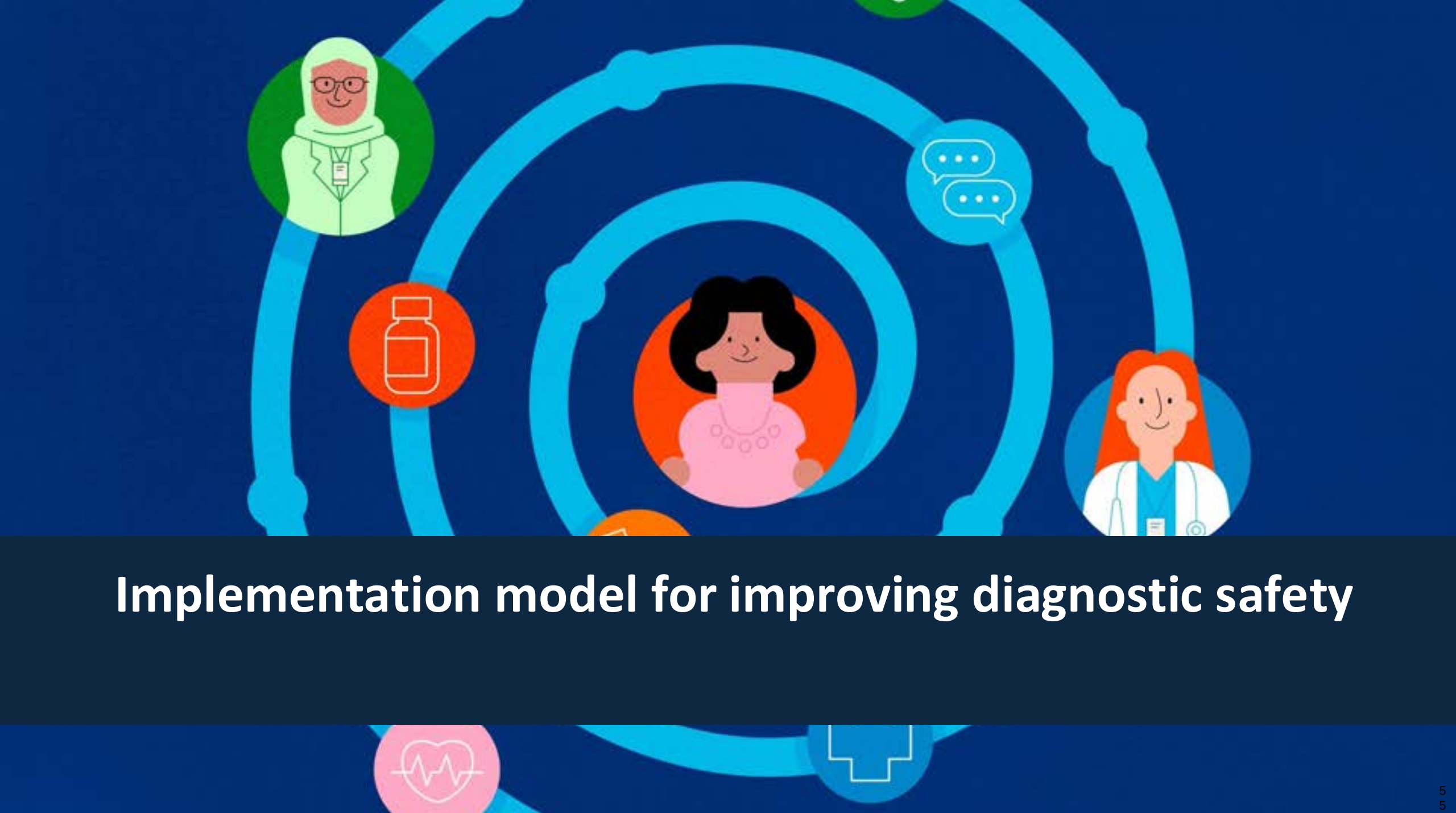


Implementation model for improving diagnostic safety

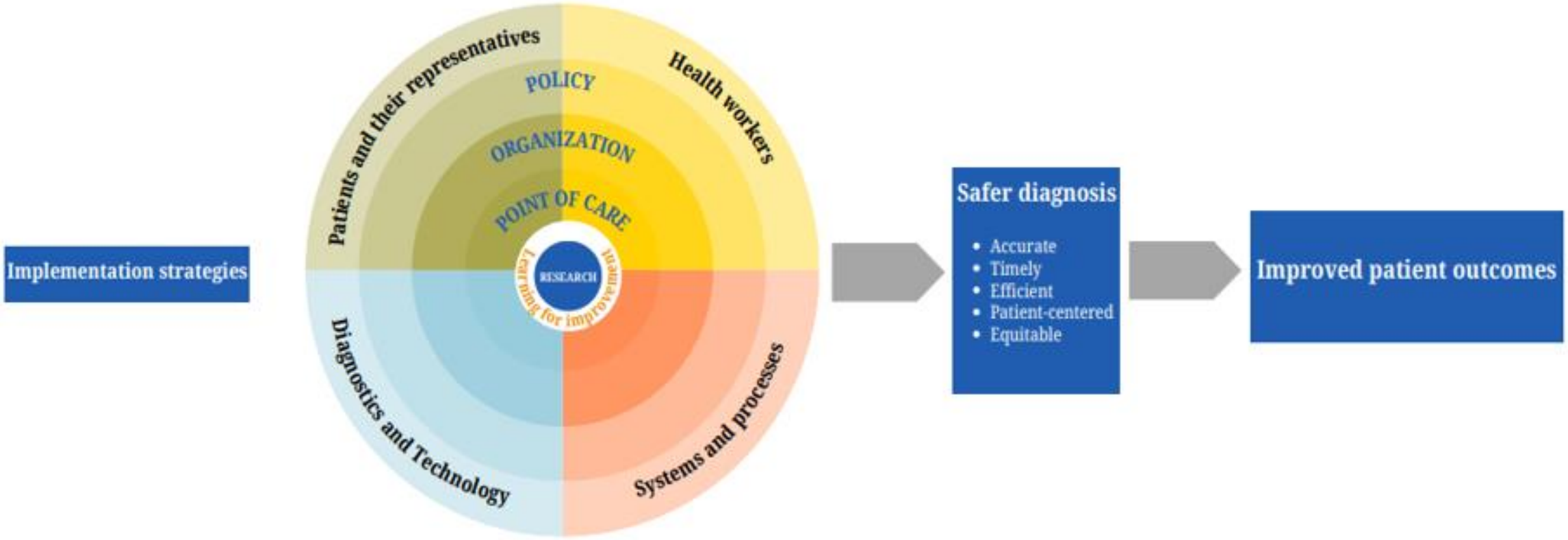
Why does diagnostic safety matter?

- Diagnostic safety is the cornerstone of patient care - it is a foundation of effective treatment and equitable care for all
- It concerns all clinical disciplines and health programmes
- Diagnostic errors are a major source of preventable patient harm
- There is an economic impact of diagnostic errors
- Multiple stakeholders are to be involved in improving diagnostic safety
- Making the change implies profound systemic challenges

Major challenges to improving diagnostic safety

- **Burden of harm**: where does the data come from?
- **Settings and levels of care provision:** do we know enough?
- **Sources of data**: are they informative enough?
- **Systemic vs specific and focused point-of-care interventions:** which are the most effective, efficient, and feasible
- **Improvement strategies**: knowledge gap - how to achieve diagnostic excellence?
- **Measurement:** how to measure diagnostic safety and monitor implementation progress?

Implementation model for improving diagnostic safety



Why developing an implementation model for improving diagnostic safety is important?

- **Systematic and systemic approach** to reducing diagnostic errors
- Integration of **best practices** and **evidence-based interventions**
- Facilitation of **engagement and collaboration** of multiple stakeholders with clear roles and responsibilities
- Mechanisms for **tracking progress, measuring the impact** of interventions and continuously **improving strategies**
- **Scaling up successful interventions and ensure sustainability** across different settings and context

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Session 2
Diagnostic safety - unveiling challenges and crafting solutions

Chair

Dr. Blerta MALIQI
Unit Head,
Quality of Care
IHS Department
WHO, HQ

Co-chair

Ingo HARTEL
Ministry of Health
Berlin, Germany

World Health Organization

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Economics of patient safety

Ingo HARTEL
Ministry of Health
Berlin, Germany

Ms Katherine DE BIENASSIS
Health Policy Analyst,
Health Division
Directorate for Employment, Labour,
and Social Affairs, OECD

World Health Organization

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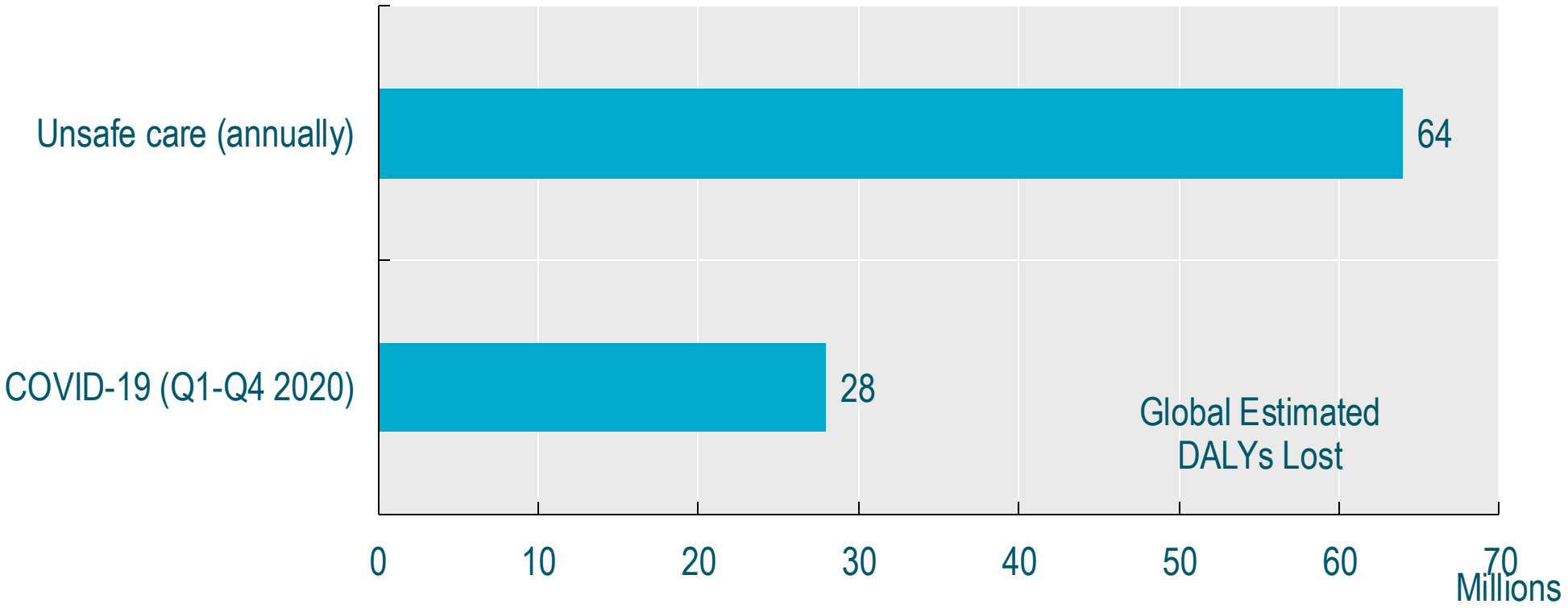
The global health burden of patient safety is massive and often overlooked

Comparative disease burden of COVID-19 and Patient Safety Failures



Source: (Fan et al., 2021[11]; WHO, n.d.[12]; WHO, 2019[13]). Note: Long-COVID not included in global estimate of DALYs lost.

Restricted Use - À usage restreint

Beyond the human costs, the financial costs to health systems are significant

On average, 1 in 10 hospitalizations results in a safety failure.

Approximately **15% of hospital expenditure** and activity in OECD countries can be **attributed to treating safety failures**.

About 50% of the patient harm burden originates in primary and ambulatory care

Safety lapses in primary resulting in hospitalisations each year may account **>7 million admissions in the OECD**.

Over half of the harm that occurs in long term care is preventable

The cost of annual avoidable admissions to hospitals from long term care facilities are **equivalent to 4.4% of all spending on hospital care**.

Restricted Use - À usage restreint

The Economics of Patient Safety Series

Federal Ministry of Health

The Economics of Patient Safety

Primary Care

Long Term Care

Medication Safety

Worker Safety

Patient Engagement

Restricted Use - À usage restreint

The Economics of Diagnostic Safety
Setting the Scene

Katherine de Bienassis, OECD

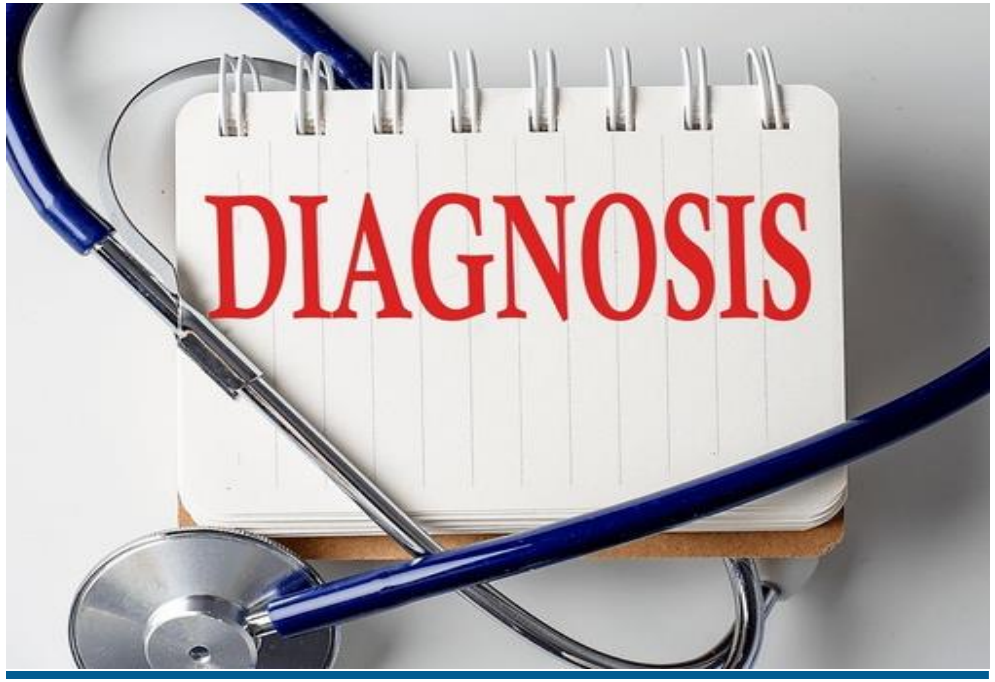
10 September 2024

Putting the focus on diagnosis

Most people will experience at least one diagnostic error in their lifetime, sometimes resulting in severe patient harm.

- Findings using patient-reported experience of safety data in Norway found that **over 15% of patients reported getting a wrong or delayed diagnosis** in connection with their hospital stay.
- Findings from the United Kingdom show that asthma **overdiagnosis and underdiagnosis** among children were potentially as high as 15% and 40% respectively.
- Globally, up to 70% of persons with chronic obstructive pulmonary disease (COPD) or asthma do not receive a formal diagnosis of the condition.

Up to 80% of all harm caused by delayed or wrong diagnosis could be preventable.

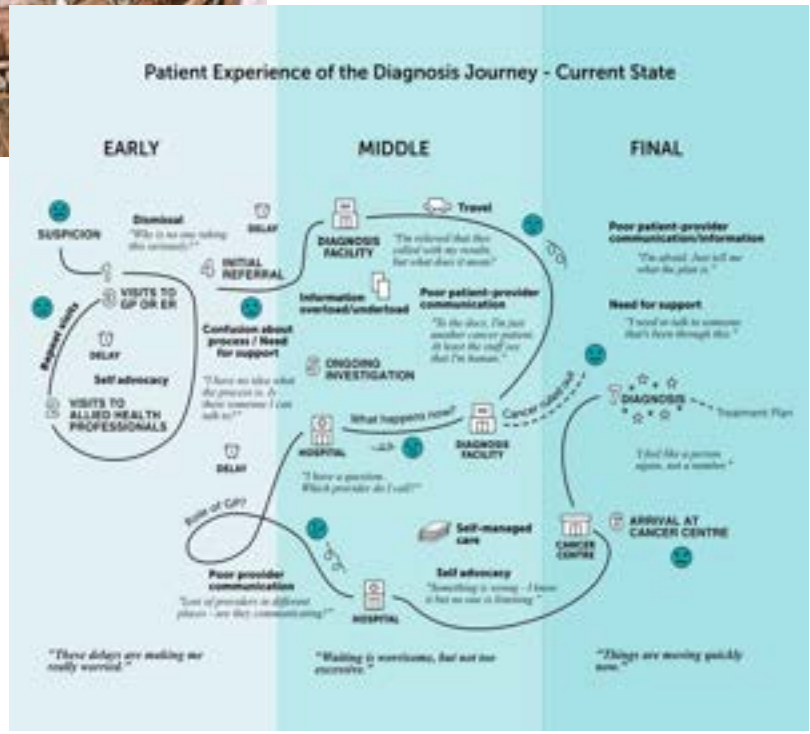


Restricted Use - À usage restreint

Medical diagnosis: embracing clinical, technological and organisational complexity

The complexity of diagnosis an important contextual factor that can impact quality of care.

- Diagnosis is an iterative process
- Basis in statistics; never 100% accurate
- Lack of consensus or routine challenges
- The path is not straightforward



https://www.all-can.org/news/blog/improving-diagnosis-in-canadian-cancer-care/

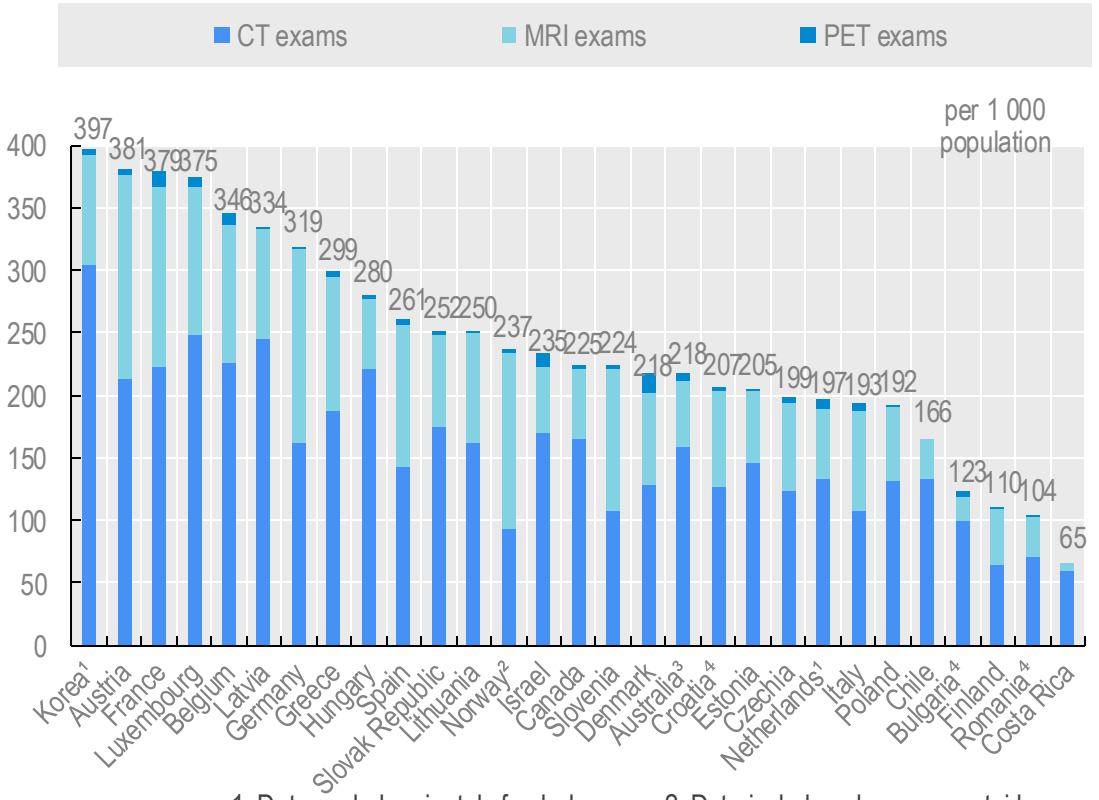
Restricted Use - À usage restreint

Foundations for exploring the economics of diagnostic safety

Key Concepts

- Diagnosis and diagnostics
- Overdiagnosis and under diagnosis
- Misdiagnosis and untimely diagnosis

CT, MRI and PET exams, 2022 (or nearest year)



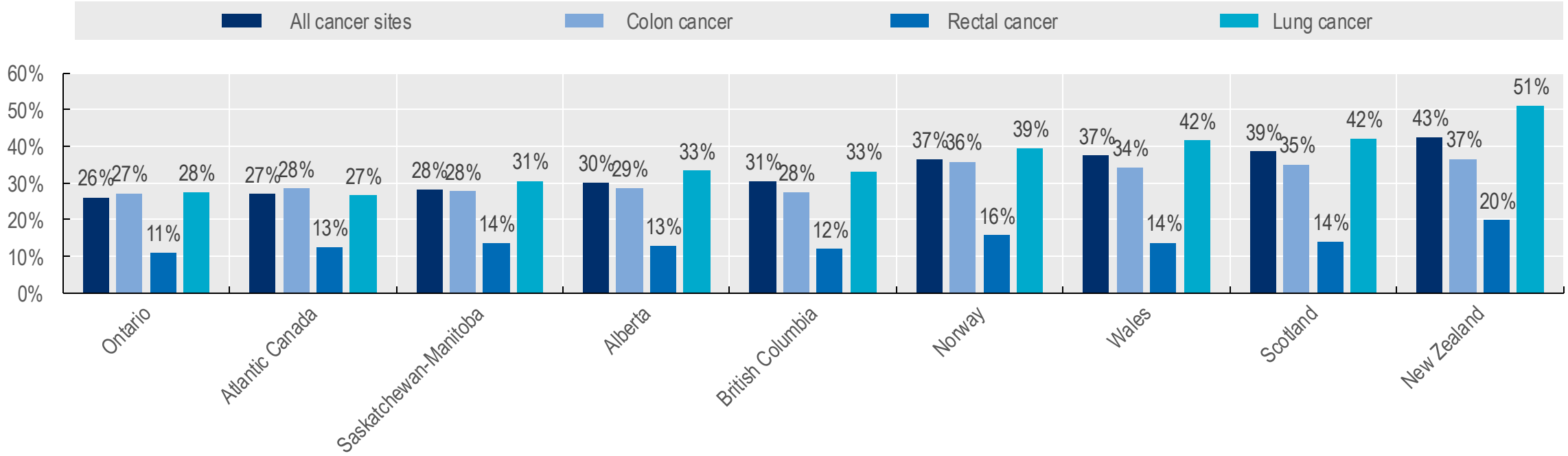
1. Data exclude privately funded exams. 2. Data include only exams outside hospital. 4. Data exclude exams on public patients.

Source: OECD Health Statistics 2024.

Restricted Use - À usage restreint

Untimely diagnosis lead to poorer patient outcomes

- **Timeliness** is an essential component of diagnostic quality and safety
- Delays can lead to **progression of disease** (or spread of communicable diseases), reduced effectiveness of available treatments, and patient anxiety.
- Cancer diagnosis following emergency presentation has been found to be associated with lower survival and **worse patient-outcomes** as compared to patients with non-emergency diagnoses, even after adjustment for stage at diagnosis



Source: McPhail et al. (2022[25]), "Risk factors and prognostic implications of diagnosis of cancer within 30 days after an emergency hospital admission (emergency presentation): an International Cancer Benchmarking Partnership (ICBP) population-based study", https://doi.org/10.1016/S1470-2045(22)00127-9.

Restricted Use - A usage restreint

The burden of diagnostic safety failure is underestimated and likely substantial to economies

- Costs associated with false-positive mammograms and breast cancer overdiagnoses exceed **$4 billion annually** in the US
- The scope of the problem and related costs are likely underestimated:
  - 2.59 million diagnostic errors occur in the US each year, resulting in 371,000 deaths and 424,000 permanently disabled
  - True costs of diagnostic error may be **20 times higher** than would be discerned by retrospective record review

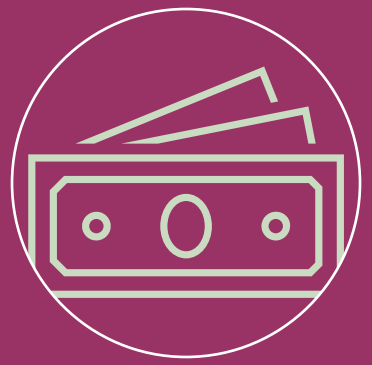
(Ong and Mandl, 2015; Dinnes et al., 2022; Newman-Toker et al., 2024; Schwartz et al., 2012).

Restricted Use - À usage restreint

Three lenses to explore

Clinical application of diagnostic tests and procedures

Behavioral dimensions related to the diagnostic process



Consequences of diagnostics and the diagnostic process for resource use

Restricted Use - À usage restreint

A stronger focus on diagnostic safety will save lives and money

Diagnostic outcomes can be improved via interventions targeting the health system, clinical environment, and individual providers

1. Structural aspects of **health system design and governance** (e.g. standards, systems, culture, incentives)
2. Interventions related to the clinical environment to improve **information exchange, culture and work environment, patient engagement and communication,** and the use of **technology and tools.**
3. Interventions to influence and improve individual decision making by supporting the development of **clinical knowledge, skill and acumen.**

Restricted Use - À usage restreint

Thank you and stay safe

The Economics of Patient Safety Series

The Economics of Patient Safety

Primary Care

Long Term Care

Medication Safety

Worker Safety

Patient Engagement

https://www.oecd.org/health/patient-safety.htm

Stay in touch

Katherine.debienassis@oecd.org

Restricted Use - À usage restreint

Interactive ice breaker: human factors

Dr Yin SHANQING
Assistant Director,
Department of Human Factors and Systems Design
KK Women's and Children's Hospital
Singapore

World Health Organization

World Patient Safety Day 17 September 2024

Experiencing Human Factors Science

(An Interactive Quiz Session)

SlideLizard

ARE YOU READY TO PLAY ?

Access the **Slido** using the following QR code.

There are **Nine** multiple-choice questions.

For each question, there is a time limit for you to respond. Select your answer as quickly as you can!

Let‘s get ready!

Q1. What is the color theme of World Patient Safety Day?

A. Blue

B. Green

C. Orange

D. Yellow

slido

Please download and install the Slido app on all computers you use

What is the color theme of World Patient Safety Day?

ⓘ Start presenting to display the poll results on this slide.

Introducing the Patient Safety Flagship Team

Q2. Who likes to eat Indian food the most?

A Irina

B Alex

C Nikhil

D Priya

E Maroua

F Ayda

slido

Please download and install the Slido app on all computers you use

Who likes to eat Indian food the most?

ⓘ Start presenting to display the poll results on this slide.

Why did you choose your answer?

Q3. Whose latest hobby is diving?

A Irina

B Alex

C Nikhil

D Priya

E Maroua

F Ayda

slido

Please download and install the Slido app on all computers you use

Whose latest hobby is diving?

ⓘ Start presenting to display the poll results on this slide.

Heuristics & Biases

instinctive mental shortcuts to simplify decision-making

influence how we gather, interpret, and use information

System 1 Thinking

intuitive; fast and efficient, especially under time pressure

prone to overlooking other details and premature closure

Get ready for Question 4!

Q4. A bat and ball together cost $1.10.
The bat costs $1 more than the ball.
How much does the ball cost?

A $0.10

B $0.05

C $0.20

D $0.90

slido

Please download and install the Slido app on all computers you use

A bat and ball together cost $1.10.
The bat costs $1 more than the ball.
How much does the ball cost?

ⓘ Start presenting to display the poll results on this slide.

System 2 Thinking

slow, logical processing; mental search for additional information

requires time and focused attention; need protection from destractions

Next up, two questions!

Q5. While going straight, if I turn the steering wheel of my car clockwise, which direction will my car turn towards?

A Left

B Right

slido

Please download and install the Slido app on all computers you use

**While going straight, if I turn the steering wheel of my car clockwise,
which direction will my car turn towards?**

ⓘ Start presenting to display the poll results on this slide.

Q6. Patient says, “This lingering, aching back pain is making it hard for me to tolerate sitting at my desk for more than an hour.”.

What do you think is the pain score (1-10)?

A 2 to 3

B 4 to 5

C 6 to 7

D 8 to 9

slido

Please download and install the Slido app on all computers you use

Patient says, “This lingering, aching back pain is making it hard for me to tolerate sitting at my desk for more than an hour.”.

What do you think is the pain score (1-10)?

ⓘ Start presenting to display the poll results on this slide.

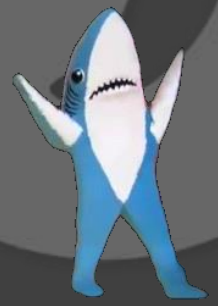
Mental Model

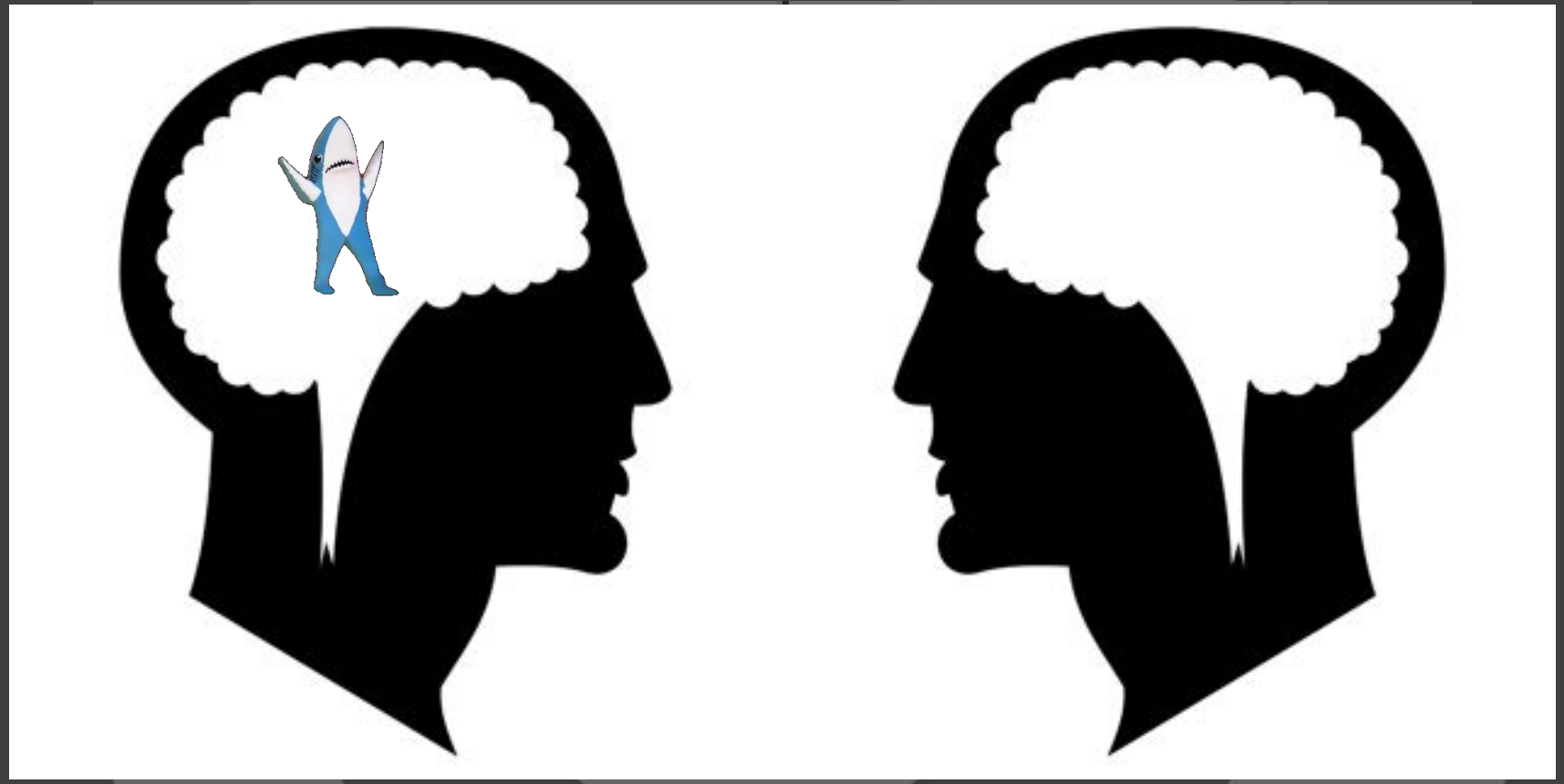
built on knowledge, information, and experiences; simplified, might vary between individuals

allows for mental simulation

These are the
last three questions!
Are you ready?

Q7. In the next image, identify which cerebral hemisphere the shark is in





A Left

B Right

slido

Please download and install the Slido app on all computers you use

In the next image, identify which cerebral hemisphere the shark is in

ⓘ Start presenting to display the poll results on this slide.

Segment	Unit	Measured	Normal Range
Right Arm	kg	3.93	2.69~3.65
Left Arm	kg	4.01	2.69~3.65
Trunk	kg	29.7	22.8~27.8
Right Leg	kg	11.20	7.93~9.69

Q8. Which measured reading is MOST out of range?

A Right Arm

B Left Arm

C Trunk

D Right Leg

slido

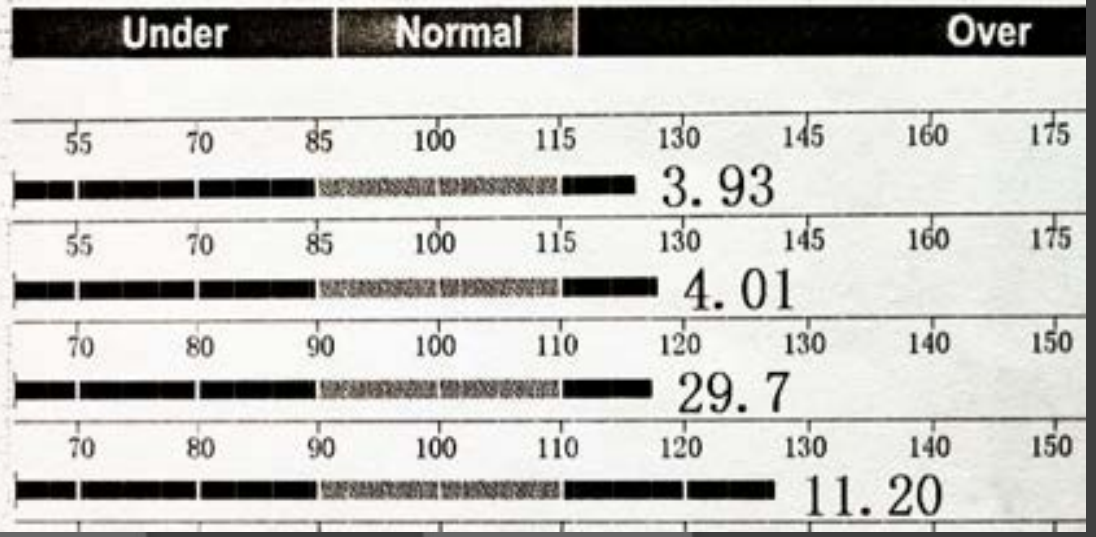
Please download and install the Slido app on all computers you use

Which measured reading is MOST out of range?

ⓘ Start presenting to display the poll results on this slide.

Segmental Lean Analysis

Segment	Unit	Measured	Normal Range
Right Arm	kg	3.93	2.69~3.65
Left Arm	kg	4.01	2.69~3.65
Trunk	kg	29.7	22.8~27.8
Right Leg	kg	11.20	7.93~9.69



Q9. Which measured reading is MOST out of range?

A. Right Arm

B. Left Arm

C. Trunk

D. Right Leg

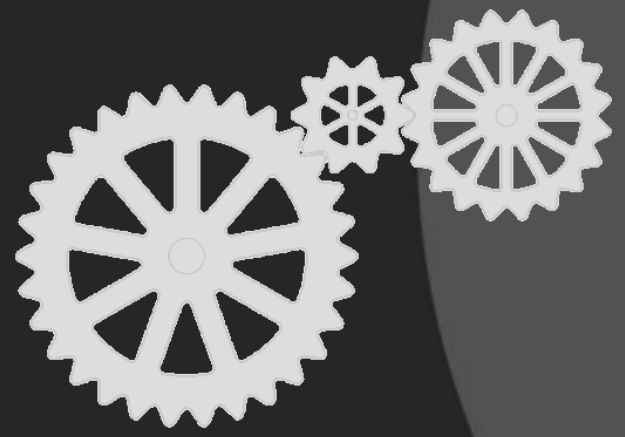
slido

Please download and install the Slido app on all computers you use

Which measured reading is MOST out of range?

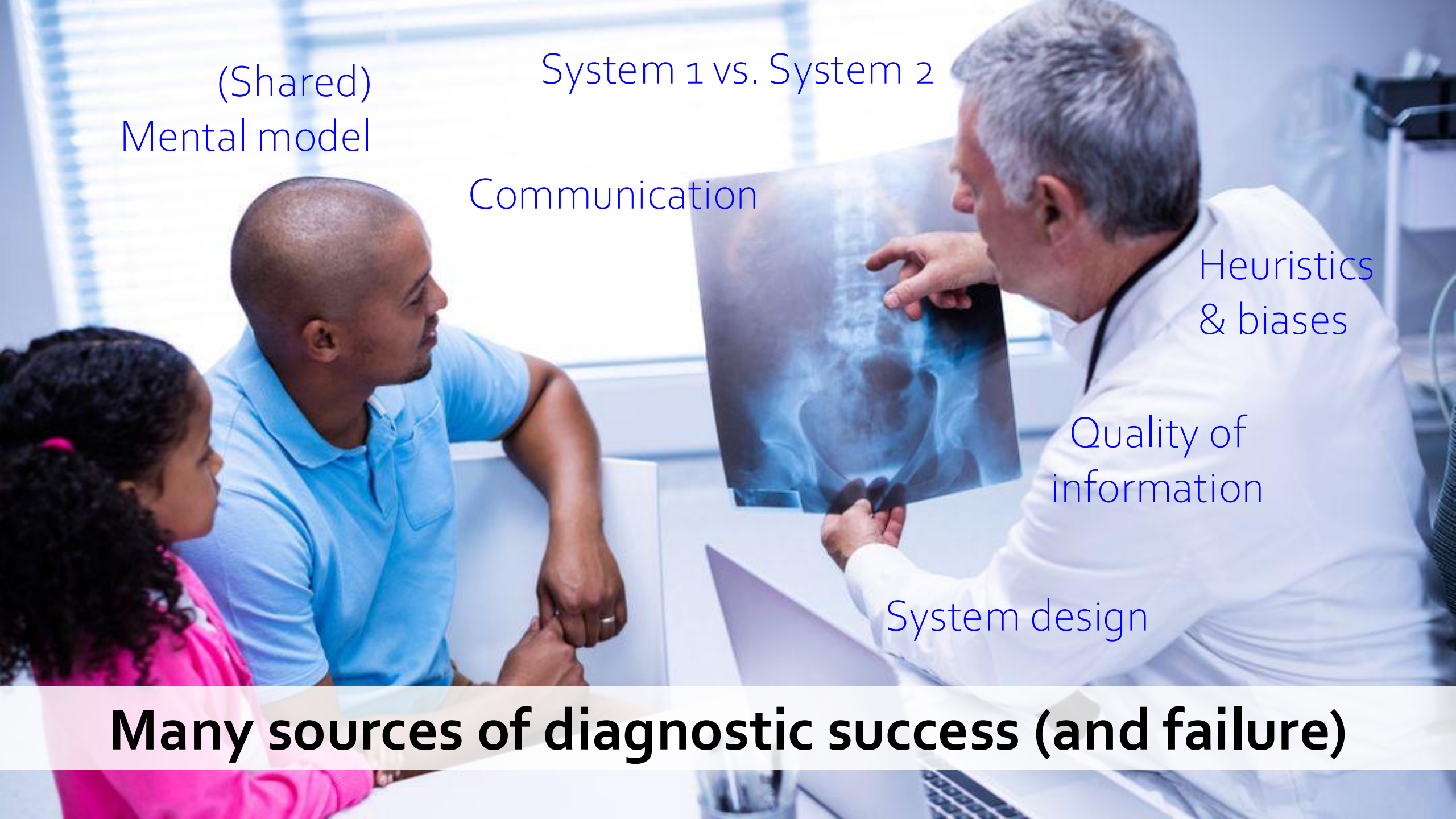
ⓘ Start presenting to display the poll results on this slide.

System Design



performance is also influenced by the design of external processes, equipment, and interfaces

consider human-centeredness; components designed to support humans at work



Many sources of diagnostic success (and failure)

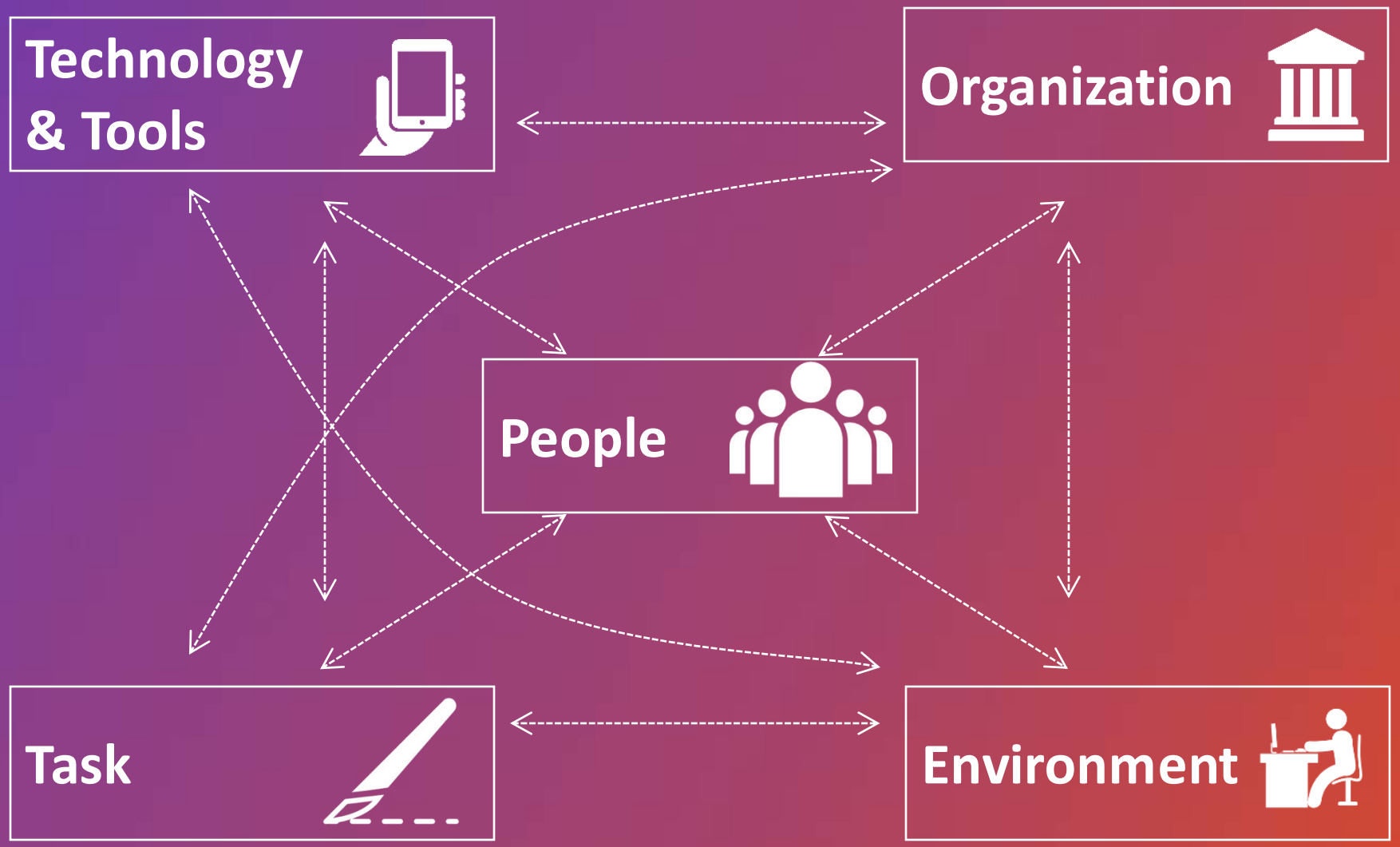
DIVERSE INTER-DISCIPLINARY SCIENCE

Many other **human factors** concepts relevant to diagnostic safety, e.g.:

- Stress & fatigue
- Situation awareness
- Cognitive load
- Experts & expertise
- Teamwork & communication

Science of improving **human performance** and optimizing **system efficiency** during **interaction**

Socio-technical System



In Summary

1) Humans are imperfect, human factors explains why.
2) Work systems can help or hinder our performance. Leverage on human factors to enhance systems.
3) Quality of decisions depends on **quality of information**.

Dr "SQ" Yin Shanqing, PhD
shanqing.yin@gmail.com
www.linkedin.com/in/shanqing

Introduction to group work

Alexandra Shaw

WHO consultant

Patient Safety Flagship

Integrated Health Services

WHO Headquarters

Switzerland

World Health Organization

World Patient Safety Day 17 September 2024

Objectives

- To review the attributes of diagnostic safety for correctness, relevance and completeness
- To critically assess the proposed implementation model in terms of structure, relation to other elements and completeness
- To evaluate the proposed interventions within the four domains at the different levels of intervention (policy, organizational and point-of-care levels)
- To identify any missed interventions and suggest relevant resources or strategies

Process

- The situational analysis, including the implementation model for diagnostic safety has been shared ahead of the consultation with all participants
- Session 2 participants have been assigned to join a working group
- There will be four groups, each with a moderator and a WHO focal point
- Moderators will introduce themselves, initiate a round of introductions of group members and brief the group on the task and questions
- The group will select a rapporteur to record and synthesize discussions
- Groups should discuss all questions outlined and notes taken in the format provided by the template
- The rapporteur will present the summary of the discussion in the plenary session tomorrow using the presentation template

Questions

- Are the proposed attributes of diagnostic safety comprehensive and relevant to all health care settings?

- What do you think of the implementation model in terms of structure, relation between different elements and completeness? Are there any critical elements or areas that are missing or need more emphasis? While answering, please put into consideration the unique needs and challenges of different health system contexts?

- What do you think of the proposed interventions. Are they comprehensive, feasible and do they cover all elements within the specific domain and level of implementation?

- From your experience, are there any best practices or innovative approaches that can be incorporated into the framework?

Presenting back to group

- Rapporteur to prepare presentation, with support of moderator, to report back to the wider group
- Powerpoint template will be shared with moderators
- 5 minutes to present the results of discussion

Groups

Group 1 – Health Workers Moderator: Annegret Hannawa Note taker: Alexandra Shaw	Room D	Ndella Konate Javiera Esperanza Fuentes Contreras Edwardo Haughton Angeliki Karaiskou Robert Velickovski	Gustavo Faissol Janot de Matos Laura Zwaan Aline Cristina Pedroso Wolf Hautz Melanie Leis Ludjie Love Smeisschelle Merilan	Blerta Maliqi Upuli Wijemanne Malathi Arshanapalai Nurshaim Tilenbaeva Pradeep Kumar Dua Ferid Shannoun
Group 2 – Patients and their representatives Moderator: Sue Sheridan Note taker: Priyadarshani Galappatthy	Room D	Henrietta Hughes Alex Adusei Terence Vanginkel Wilde Helen Haskell	Yin Shanqing Maria Pilar Astier Peña Hussain Jafri Ogusa Shibata	Tereza Kasaeva Anshu Banerjee Suraya Dalil
Group 3: Systems and processes Moderator: Albert Wu Note taker: Ayda Taha	Room E	Deneke Ayele Abebe Ali Asery Tatiane Batista Mustapha Elhousni Tania Cardona Aidan Fowler	Britta Gerloff Ingo Härtel Tuija Ikonen Jitendra Nath Srivastava	Katherine De Bienassis Aparna Singh Shah Emilie Van Deventer Matteo Cesari
Group 4: Diagnostics and technology Moderator: Ana Aceves Capri Note taker: Nikhil Gupta	Room E	Anthony Staines Julia Tainijoki-Seyer Kor Virya Frédéric Cave Kelly M Smith Shin Ushiro	Mark Graber Masaru Kurihara Abdulelah Alhawsawi Antonia Gama Caroline Samer	Ratko Magjarević Carmel Moran Tomris Özben Mondher Letaief Roberto Verna

Improving diagnostic safety: WHO interventions

Moderator
Dr. Blerta MALIQI
Unit Head,
Quality of Care
IHS Department
WHO
Geneva, Switzerland

World Health Organization

World Patient Safety Day 17 September 2024

Communicating and championing WPSD: the 2024 campaign

Dr. Ayda Taha
Technical officer
Patient Safety Flagship
Integrated Health Services
WHO Headquarters
Switzerland

World Health Organization

World Patient Safety Day 17 September 2024

World Patient Safety Day 17 September 2024

World Health Organization

WHO Global Public Health Days

Previous World Patient Safety Days

2016-2019

Global Advocacy

2019

World Patient Safety Day established (WHA 72.6)

Speak up for patient safety!

2020

Safe health workers Safe patients

2021

Act now for safe and respectful childbirth!

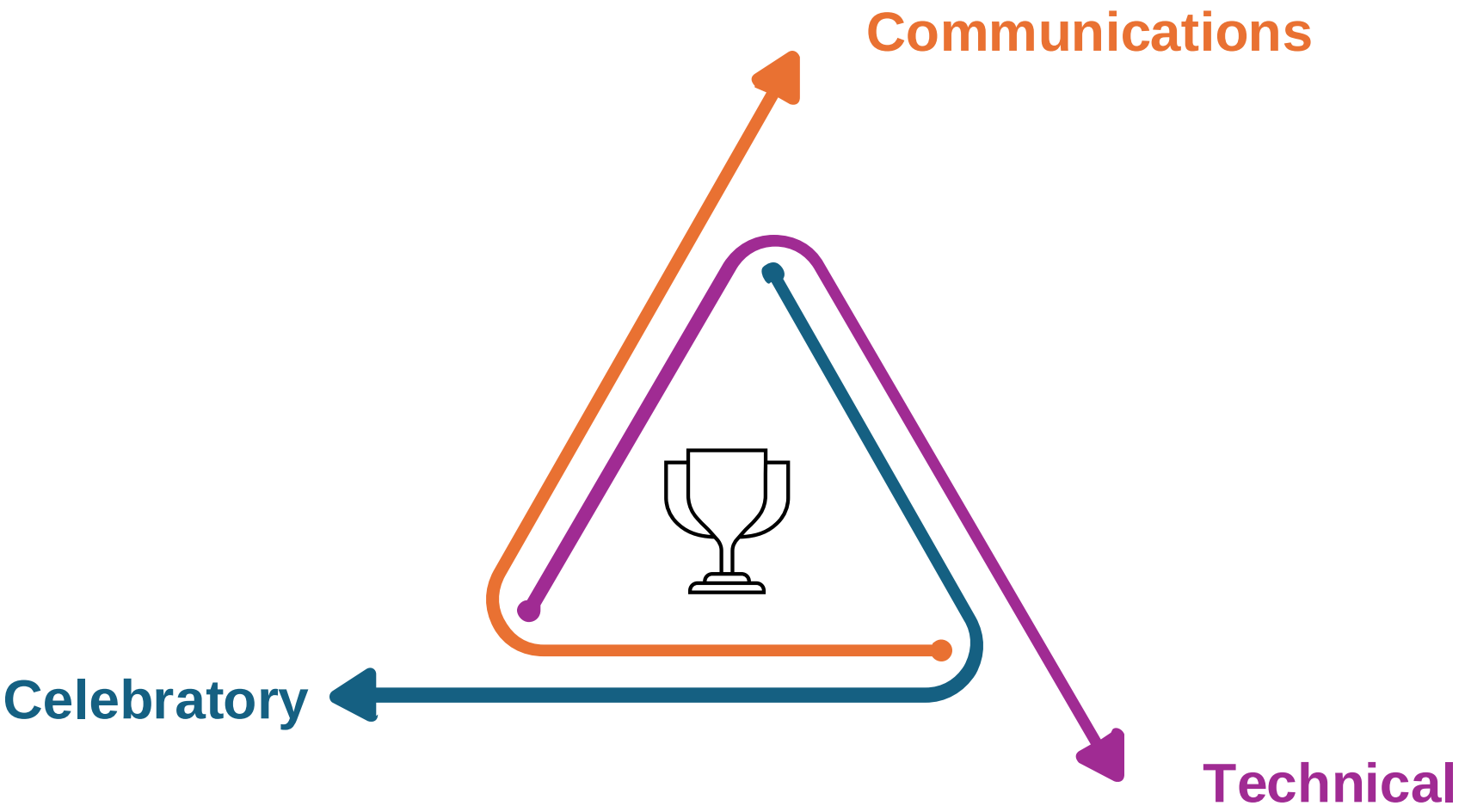
2022

Medication Without Harm

2023

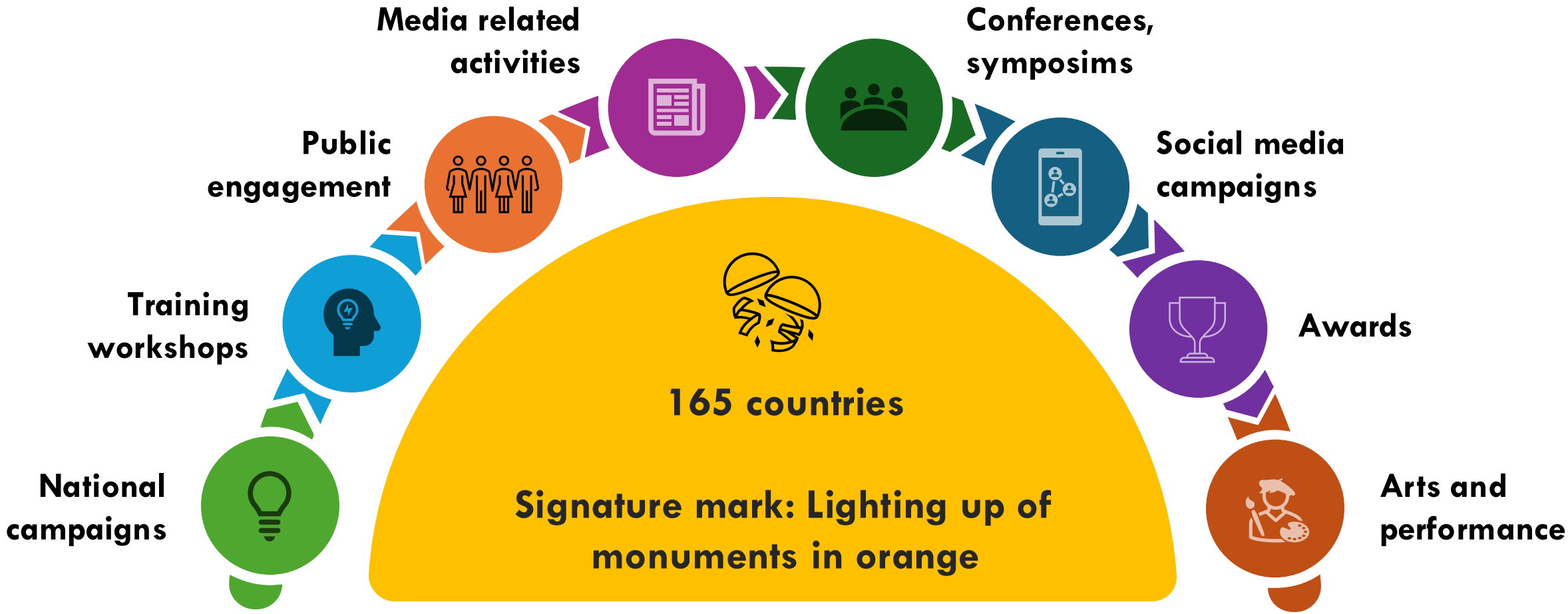
Elevate the voice of patients!

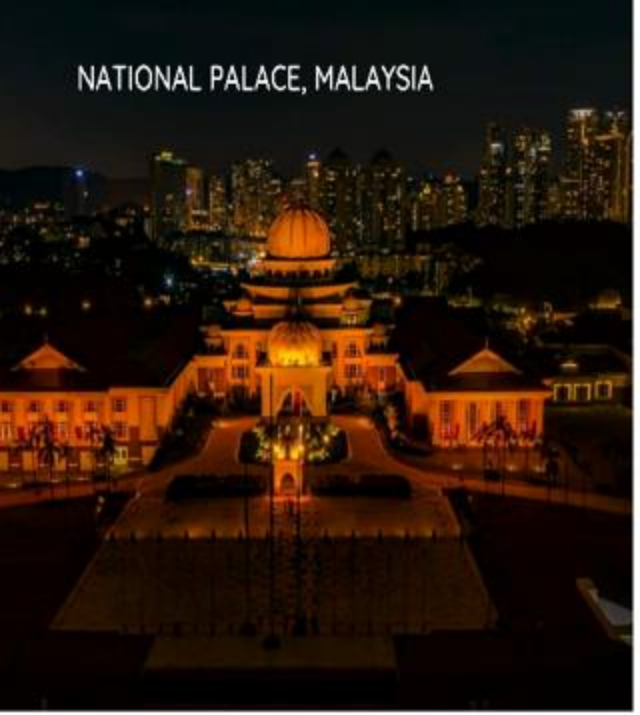
Campaign components

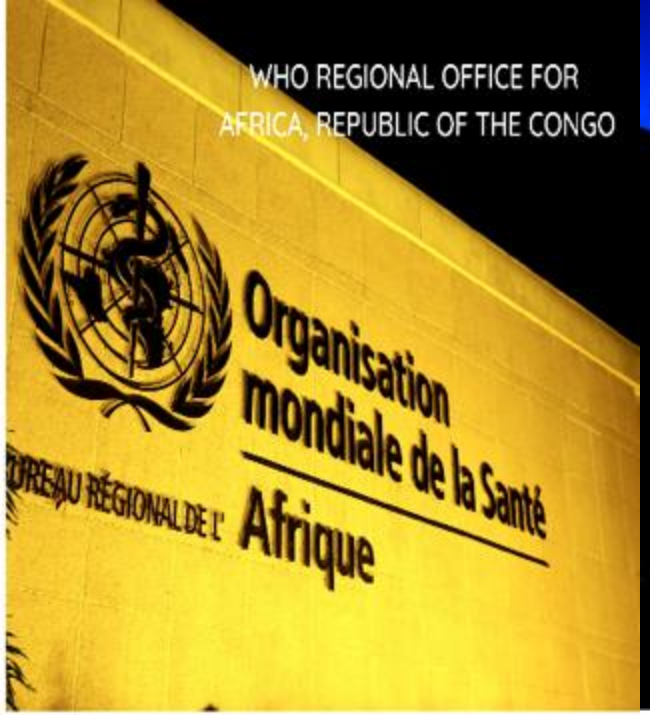


World Patient Safety Day 17 September 2024

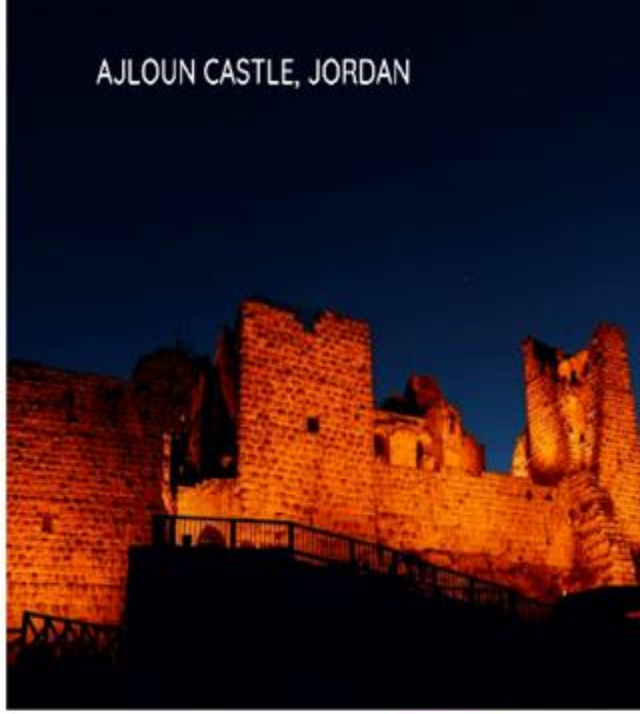
World Health Organization




NATIONAL PALACE, MALAYSIA


WHO REGIONAL OFFICE FOR
AFRICA, REPUBLIC OF THE CONGO
Organisation
mondiale de la Santé
BUREAU RÉGIONAL DE L'
Afrique

WIDMANN PALACE, ITALY


AJLOUN CASTLE, JORDAN

FLORALIS GENÉRICA,
ARGENTINA

JET D'EAU, SWITZERLAND

KINGDOM TOWER,
SAUDI ARABIA

JERUDONG PARK CRYSTAL
ARCH - BRUNEI

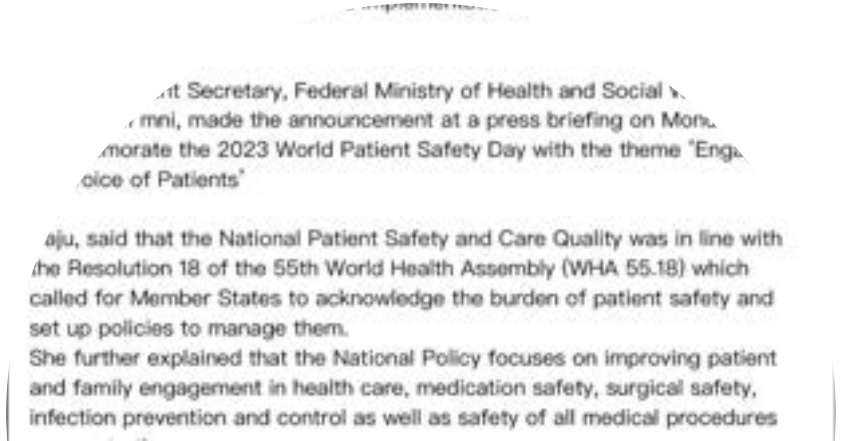
GOVERNMENT PALACE,
TIMOR-LESTE
PALÁCIO DO GOVERNO

CN TOWER, CANADA

High-level officials' participation

ay 2023 | Minister for Health

views | 2 months ago



t Secretary, Federal Ministry of Health and Social
mni, made the announcement at a press briefing on Mon
morate the 2023 World Patient Safety Day with the theme 'Eng
oice of Patients'

aju, said that the National Patient Safety and Care Quality was in line with
he Resolution 18 of the 55th World Health Assembly (WHA 55.18) which
called for Member States to acknowledge the burden of patient safety and
set up policies to manage them.
She further explained that the National Policy focuses on improving patient
and family engagement in health care, medication safety, surgical safety,
infection prevention and control as well as safety of all medical procedures

Patient engagement activities

WALK the TALK
World Patient Safety Day

2023病人安全麻吉先前行健走活動

EVENTO EM ALUSÃO AO
DIA MUNDIAL DE SEGURANÇA
DO PACIENTE
Santa Juliana

Patient organizations activities

PATIENT'S VOICE

WORLD

IPSG-1
IPSG-2
IPSG-3
IPSG-4
IPSG-5
IPSG-6
"PATIENT SAFETY IS A TEAMWORK"
PATIENT SAFETY

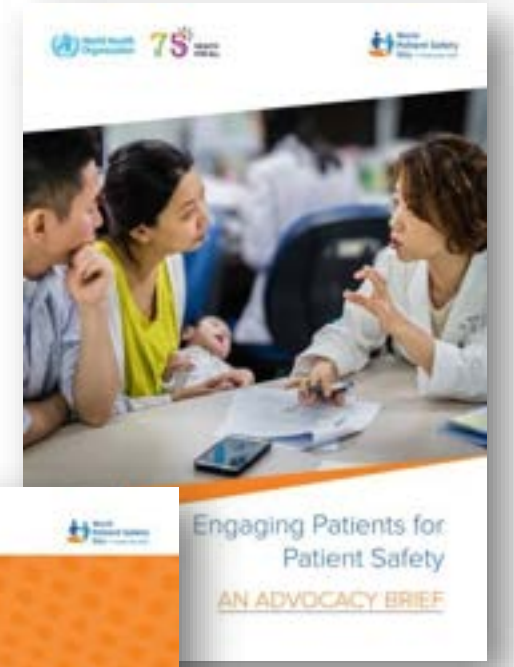
YOUR
VOICE
MATTERS!
PATIENT SAFETY

WHO activities

Technical resources

2020

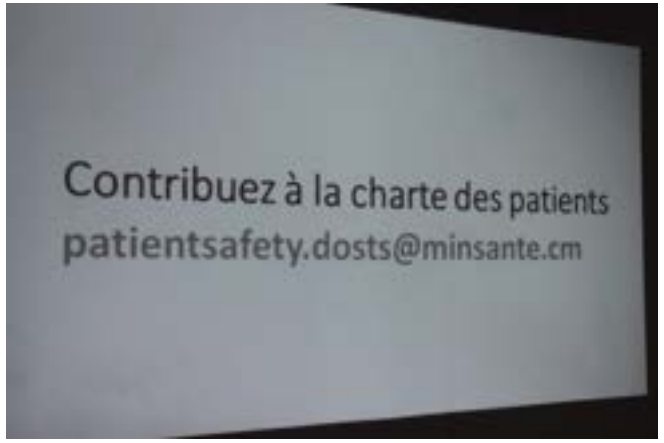
2022



2021

2023

Mobilizing global action



The Ministry of Public Health and Social Welfare, through the Quality Directorate, recalls its commitment to this challenge and encourages patients to exercise their right to ask questions and together make health care safer.

World Patient Safety Day 2024: ‘Improving diagnosis for patient safety’

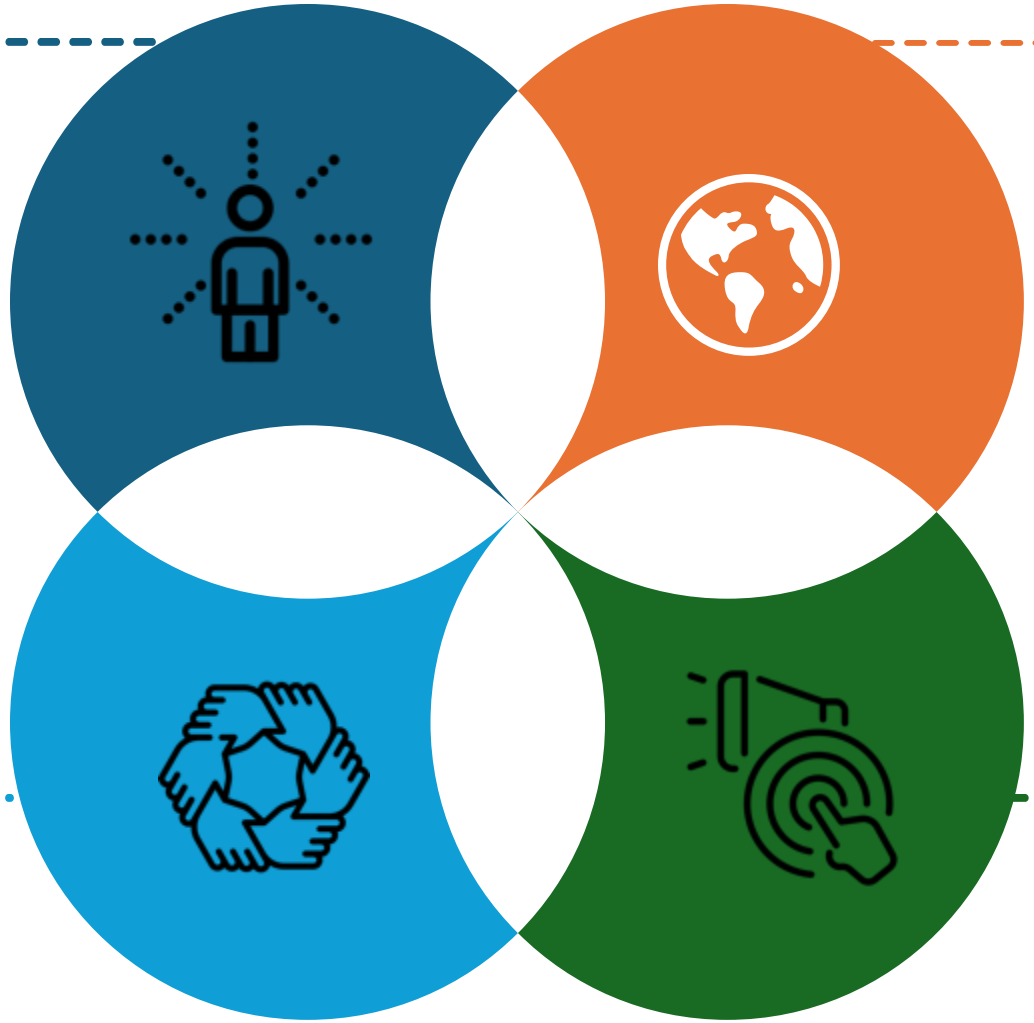
World Patient Safety Day 17 September 2024

Objectives of World Patient Safety Day

World Health Organization

Raise public awareness of diagnostic errors

Give prominence to diagnostic safety in patient safety policy



Foster stakeholder collaboration

Empower patients and families

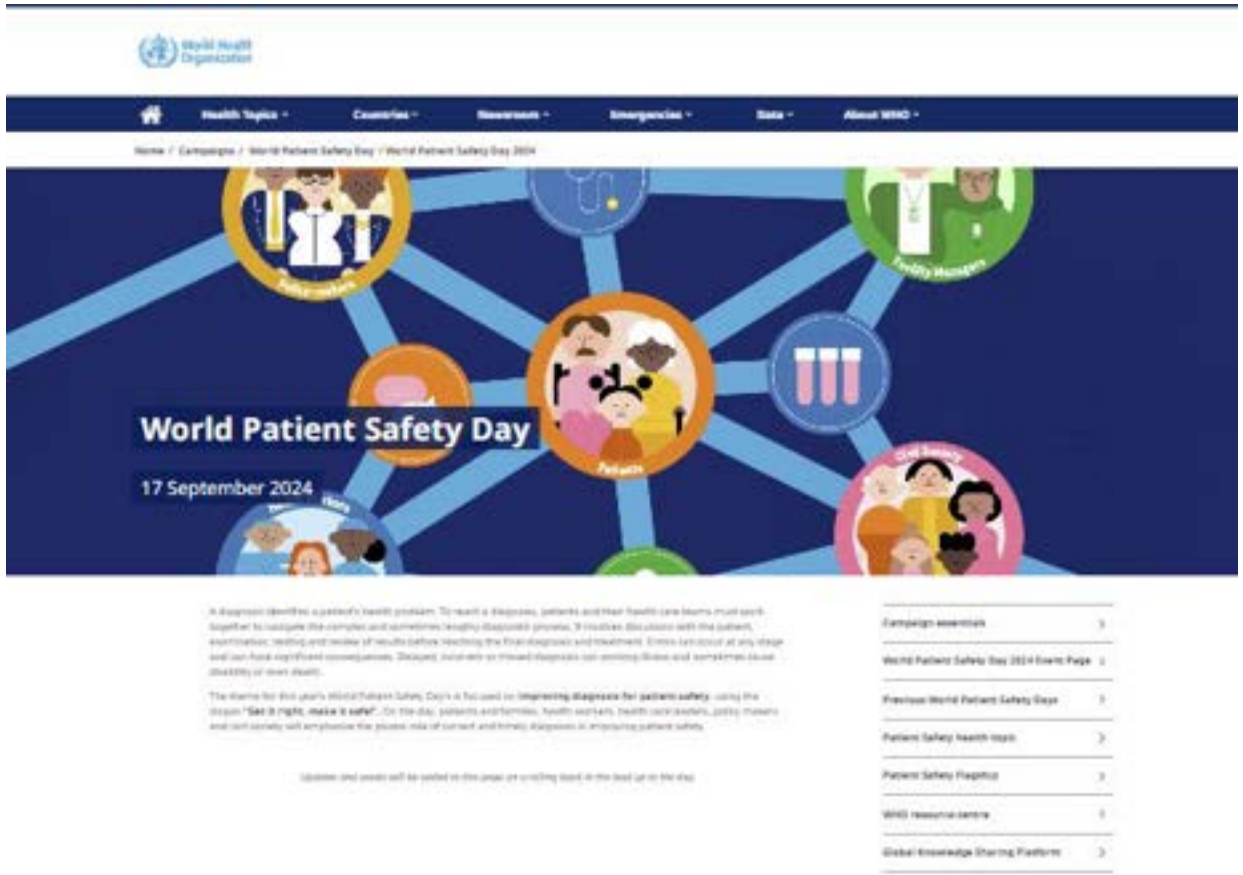
World Patient Safety Day 17 September 2024

Target audiences

World Health Organization

Communications component

Campaign website



World Patient Safety Day 2024 (who.int)

- ❑ Campaign messages
- ❑ Objectives
- ❑ Calls to action
- ❑ Advice for stakeholders
- ❑ E-survey to share plans
- ❑ WHO resource centre
- ❑ Global Knowledge Sharing Platform

Campaign materials

Web banner

Roll up banner

Zoom backgrounds

World Patient Safety Day 17 September 2024

Campaign materials

Posters

World Patient Safety Day 17 September 2024

Campaign materials

PowerPoint template

World Patient Safety Day 17 September 2024

Campaign materials

Souvenirs' design

World Patient Safety Day 17 September 2024

Campaign materials – Social media

Infographics

Quiz backgrounds

Static Tiles

Campaign materials – Videos

- Explainer video: Health workers
- Social cut: General public
- Patient and health worker video testimonies: Social media

Celebratory component

Additional activities

- Global consultation
- Press release
- Lighting up of Jet d'Eau in orange on 17 September

Kind requests

- Please

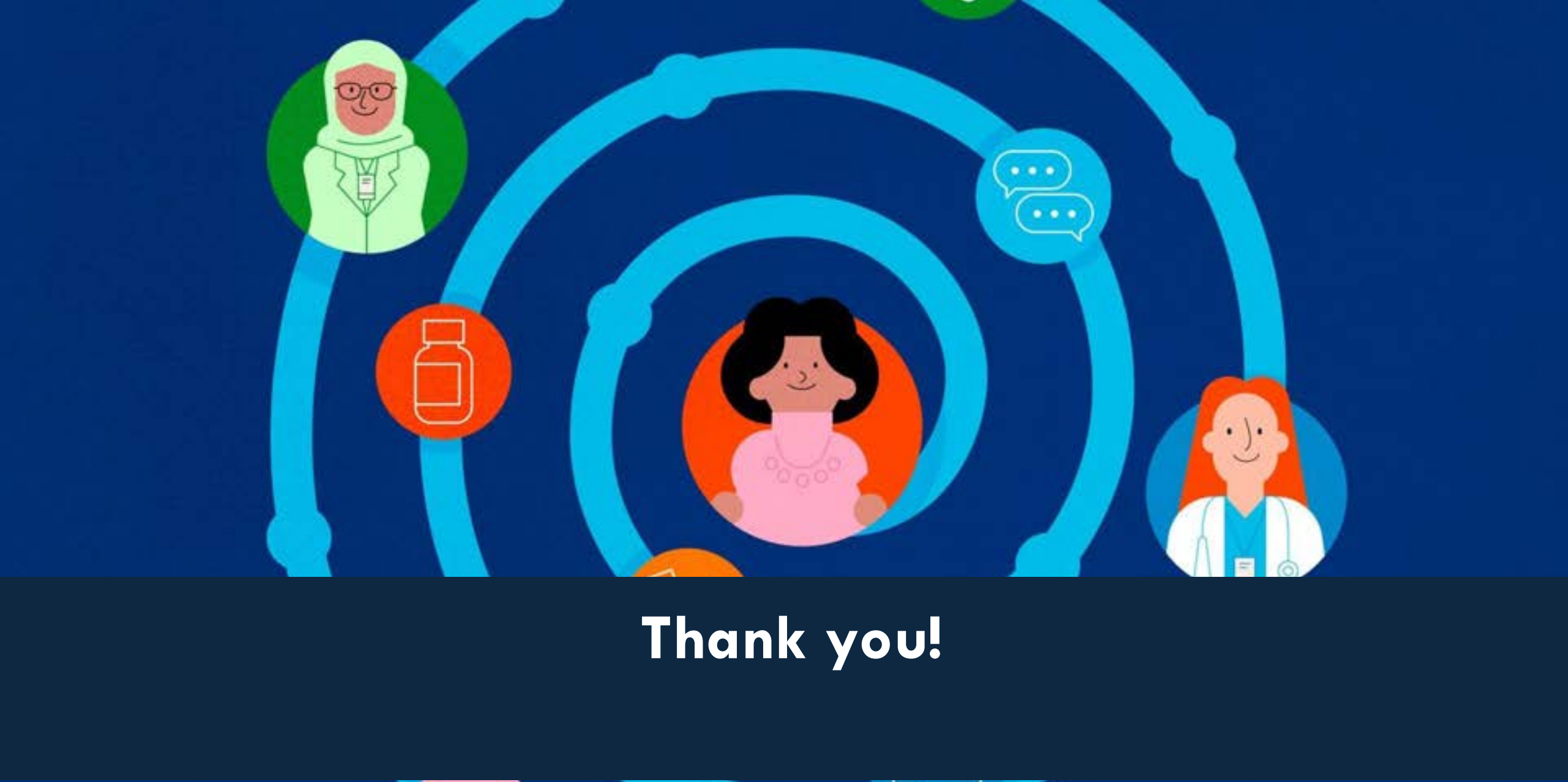
❑ Amplify the campaign messages within your networks and on social media 'Corporate and personal'. #WorldPatientSafetyDay #PatientSafety

- World Health Organization | LinkedIn
- World Health Organization (WHO) | Geneva | Facebook
- World Health Organization (WHO) (@WHO) / X
- World Health Organization (WHO) - YouTube
- TikTok - Make Your Day

❑ Share your activities on GPSN, through the survey or send an email to patientsafety@who.int

❑ Share your diagnostic safety resources on the Global Knowledge Sharing Platform

❑ Light up a monument in orange on 17 September



Thank you!

Closing remarks of Day 1

Sir Liam DONALDSON
WHO Envoy for
Patient Safety
WHO headquarters

World Health Organization

World Patient Safety Day 17 September 2024