# Patient Safety 2007: Conference Report

**MK Tilney**
**Conference Academic Chair,**
**Commonwealth Medical Association**

*Patient Safety 2007 was conceived at the Executive Board meeting of the Commonwealth Medical Association (CMA) meeting in January 2006, and subsequently came to fruition in February 2007. It was hosted by the Medical Association of Malta and supported by the European Social Fund and the Commonwealth Secretariat. It also received the support of the World Alliance for Patient Safety of the World Health Organisation, the Maltese government and a number of other sponsors, who are gratefully acknowledged.*

A growing body of research evidence points to the fact that errors in health care are common and know no geographical boundaries. While their context may differ, no country - rich or poor - can claim to have fully come to grips with the problem of patient safety. This is an area of major importance to all stakeholders in healthcare-it is the bottom line in quality of care, and is of interest to all branches of the medical profession, as well as spanning the inter-professional divide with the professions allied to medicine. Last, but certainly not least, it is of interest to patients!

The CMA considers that it is important to sensitise Commonwealth Medical Association members to Patient Safety issues, and also to consider how this impinges upon developing and newly developed countries. The proceedings and slide presentations will be publicised on the Commonwealth Medical Association website due to be launched shortly.


**CMA Executive (from left to right): Dr N Arumugam, Dr O Owusu-Danso, Dr EK Donaldson, Dr MK Tilney, Prof Agyeman Badu Akosa, Dr Martin Balzan, Datuk Dr P Krishnan, Dr S Arulraj, Dr K Gungah.**

The conference was formally opened by His Excellency, Dr E Fenech Adami, President of Malta, after welcome speeches by Dr S Fava, President, Medical Association of Malta and Prof. Agyeman Akosa, President of the Commonwealth Medical Association.

**The first plenary session covered *Overview and Development of Patient Safety*.**

**Dr Myra Tilney** addressed **Quality of Care and Patient Safety**, **the context, situation and evidence-base** identifying the main concepts in the development of quality control, quality assurance and quality improvement methodology within industry and how these have been applied to services and more recently to healthcare. The concept of utilising a Systems approach in healthcare and it's improvement within a complex adaptive system was described, as well as looking at different facets of care. Safety is the bottom line in healthcare and has been so for many centuries, as exemplified by the ancient adage *Primum non nocere* (First do no harm). The attributes required for safe care were explored. Many factors affect expert care, including having adequately supported processes for quality improvement, and organisational support. Other important concepts include zero tolerance for error, building quality into process, and the development of a safety culture. Common problems and high risk sites were addressed. Change requires educational approaches to develop professionalism and improvement using Kolb's learning cycle (describing adult learning), and Deming's PDSA (Plan-Do-Study-Act) Cycle-with patients forming an integral part of the process.

**Prof James Reason, Emeritus Professor, Manchester University** presented **Is it the System-or is it the People? A Question at the Heart of the Patient Safety debate**. In all hazardous industries, there has been an increasing awareness of the importance of systemic factors in understanding safety. It is clear that when adverse events occur, they are usually the result of a sequence of events, rather than individual error. The 'systems view' has been strongly endorsed by the US Institute of Medicine reports on improving healthcare, as well the UK Dept of Health reports, and in comparable reports in Australia, New Zealand and Canada. There must also be the recognitions of the distinctive and very personal features of health care, which is delivered on a one-is-to-one-basis, with high error opportunity and small margins of error, on a background of incomplete knowledge, and where adverse events are investigated locally. Reliability is a dynamic non-event. A balance needs to be struck between system and person models in health care. The person model usually means 'human as hazard', that is to say that when errors occur the individual at the 'sharp end' is blamed and isolated. But there is also 'human as hero', where the individual identifies and compensates for the errors that have developed within the system. Error Reporting systems are used in aviation enabling near misses to be investigated, and system safeguards to be introduced. Speculative cycles around two-sided person and system axes were outlined.

**Dr Stephanie Bown, Director of Education and Communications, from the Medical Protection Society** presented 'Pitfalls in Practice'. Clinicians face 'multiple jeopardy', with liability to proceedings in different areas when adverse events occur. The number of claims against specialists and general practitioners is growing, and for ever increasing amounts running into millions of pounds. Patient safety was the single most frequent cause for complaints; 3.7% of admissions suffered adverse events, with 1 in 4 being due to negligence. However, few complaints were due to negligence; and 2 out of every 3 complaints were found not to be due to negligence. Poor communication underpinned many complaints, precipitating factors including system

errors with adverse events and incorrect care. Being available, understanding the patient's perspective, being empathic, and pitching explanations at patients' level were all associated with reduced medico-legal risks. If things do go wrong, it is important to acknowledge this, to find out the facts, and apologise where appropriate. It is imperative to identify the issues to prevent recurrence, and adopt these into future practice. She concluded by listing her keys to a peaceful life- including maintaining competence, good record keeping, continuing indemnification, appraisal and certification.

**The second plenary session looked at *Accountability and Learning Systems***

**Dr Jesper Poulsen,** from the **Standing Committee of European Doctors,** addressed **Reporting Systems, National Medical Associations and Developing a Safety Culture**. Many studies have demonstrated that the health sector is not safe, with significant mortality and morbidity due to error. Up to 11% of hospital admissions lead to severe harm-but this would be higher if it were not for the extreme vigilance of healthcare staff. Safety is the bottom line in healthcare; and every system is perfectly designed to achieve exactly the results it gets. Patient injury is multifactorial in origin; with human and system errors being causes. Human error can be reduced-but cannot be completely avoided-even an accuracy of 99.99% will result in a low error rate with potentially serious consequences. Errors can be perceived as improvement tools to prevent recurrence. The Danish Patient Safety Act provided the framework to put this into practice, based upon extensive stakeholder involvement. It requires healthcare practitioners to report any adverse events or near misses, to a central board that is obliged to analyse such reports in a non-identifiable manner, with a view to preventing future recurrences. No doctor or nurse can be subjected to disciplinary measures of any kind as a result of these reports, according to the law.

**Dr Heikki Palve, Chief Executive Officer of the Finnish Medical Association,** spoke about the **No-Fault Compensation System** in Finland, which was the first of the Nordic countries to introduce a No-Fault Patient Safety law, in 1987. It was shortly followed by Denmark (1992), Sweden (1997), Iceland (2001) and Norway (2003). A Patient Insurance Centre incorporates all insurances underwriting health insurance; it coordinates insurers' policies, protecting the rights of patients, policyholders and medical personnel, as well as carrying out surveys and reviewing the area under its' responsibility. A Patient Insurance Pool grants insurance in the public sector and looks after reinsurance. Medical Insurance is mandatory, covering all medical activity including individual practitioners, organisations providing healthcare,(public and private), medical transportation services and pharmacies in respect of prescription drugs sold on the premises. Medical Insurance is covered by employers, with the Finnish Medical Association covering individual doctors. The system is financed by contributions from healthcare organisations and practitioners. An injured party can make a claim that is assessed by an expert board; any recommendations may be accepted, and settled; alternatively, the injured party has the option of asking for a reassessment. A dissatisfied claimant may make an action for damage to the courts at any stage. Premia are related to risk levels, with a nurse paying 25 euros annually, physicians

490 euros, surgeons 1249 euros and dentists 953 euros; businesses pay rates related to risk and payroll. Failure of insurance leads to substantial penalties.
The introduction of this system has introduced the no fault-no guilt-principle with a medico-legal board solving the claims for adverse events. Since its' introduction claims have now stabilised with similar levels of acceptance. The system uses the standard of an experienced professional person and has enabled better analysis of adverse events.

**The afternoon plenary addressed *Ongoing Developments in Patient Safety***

**The WHO World Alliance for Patient Safety was represented by Prof J Reason**, who works with the WHO as an expert in the area. The Alliance is addressing the challenges in identifying best practices to improve patient safety, and their implementation so as to ensure that the right measures are introduced with 100% accuracy. It aims to work with patients so as to improve care through their experiences. Major objectives identified include safer surgery, and the draft reporting guidelines for adverse events, which were led by Lucian Leape. These recommend the reporting of a wide range of safety information that would protect the reporter and not disclose identities. Timely analysis by experts, with recommendations for action and rapid dissemination should lead to corrective action that will lead to change. A standardised taxonomy is being developed, as well as the development of a WHO Collaborative Centre to coordinate developments, and influence key stakeholders. It aims to identify quick 'fixes' that will result in improved patient safety. An implementation programme developed with the Commonwealth Fund is ongoing in five countries over a five year period, focusing on *Standard Operating Procedures* for handovers, wrong site/procedure/person errors, medication errors, high concentration drug errors and hand hygiene practices. A Governing Council for Research with internationally agreed research priorities has been established. It is developing methodologies, prevalence studies in developing countries and capacity building for patient safety research. The overall aim is to ensure that healthcare becomes safer year on year.

**Dr N Arumugan, President of the World Medical Association (WMA),** addressed **Patient Safety in Developing Countries**, using his native Malaysia as an example. Developing countries face many challenges in the area, not least being the risk of unsafe injections. Malaysia has a Quality Assurance Programme that was instituted in 1985 to improve care through six main approaches. A national hospitals indicator programme, internal peer review in mortality meetings in various areas, hospital accreditation, clinical risk management, clinical care pathways, and a soft skills approach including patient satisfaction surveys and complaints management. Infection control has been developed in secondary, and recently in primary care. The Malaysian Society for Quality in HealthCare offers objective evaluation spanning the public and private sectors. The World Medical Association Declaration on Patient Safety (2002) noted 'there should be a non-punitive culture for confidential reporting healthcare errors that focuses on preventing and correcting systems failures and not on individual or organization culpability'. National Medical Associations should work with key stakeholders to establish systems that will facilitate patient safety, both through continuing professional development and interaction with other medical associations especially as regards

'lessons learnt'. WMA has a statement regarding safe injecting practices and the requirement to focus on aspects of the 'supply chain' in the provision of safer care-i.e. all aspects from purchasing to supply and usage have to be addressed. The wider aspects of professionalism include the basic responsibility to teach, to participate in Continuing Professional Development (CPD)/Continuing Medical Education (CME), and develop and teach Medical Ethics. Doctors need to take on Management roles, and develop inter-professional dialogue, as well as being better advocates for their patients. In short, they have to develop their leadership role to develop better healthcare.

**Dr Archie Sittie, of the Centre for Scientific Research into Plant Medicine, Mampong-Akuapem, Ghana** presented a review on traditional and alternative healthcare and patient safety. He addressed standardization and quality assurance issues, toxicity of herbal medications and herb-drug interactions. Herbal medicine is widely used in the developing and increasingly, in the developed world, as herb supplements are added to foods and marketed as 'healthy alternatives, often without consideration for potential interactions and toxicity. 90% of Germans have used some form of alternative healthcare at some stage, with increasing figures in many countries. Many alternatives exist ranging from Chinese, Aryuvedic, and Unami medicine, to homeopathy, chiropractic and indigenous medicine. Many orthodox medicines have been developed from plant sources-e.g. Tamiflu from Chinese star anise. However, there are concerns regarding the potential for toxicity e.g. hepatic toxicity and renal damage have been documented as a result of herbal preparations, as well as toxic contaminants in non-standardised preparations. The latter have included Thallium, Lead, steroids, and Mercury. Increasingly, medical practitioners need to be aware of the need to ask patients what alternative preparations or care they may be using. To reduce the potential for interactions, alternatives should be avoided, or at least, they should be taken at different times. An awareness of synergistic/additive affects is required (e.g. hypoglycemic) and ideally patients on multiple medications should avoid adding other preparations because of the increased potential for toxicity. The way forward should include an agreed regulatory framework for proper use in keeping with WHO proposals, as well as regulatory mechanisms to control the quality and safety of preparations. This should be in conjunction with better training for alternative healthcare practitioners, as well as improved training for healthcare professions regarding potential risks and risk reduction. Finally, better information on proper usage should be provided to consumers.

**The second day commenced with a plenary session addressing *Patient Safety and Medical Ethos.***

**Dr Edwin Bowman, Chairman, International Committee, British Medical Association,** spoke about **Maintaining Professionalism through the Quality Agenda.** The challenges to professionalism, the quality agenda, (quality improvement, assurance and control), the UEMS models and moving towards a new professionalism were key areas addressed. Professionalism requires knowledge, altruism, commitment and autonomy, amongst other attributes-but it is being increasingly questioned by society. Doctors

should be learning and expanding their knowledge, developing new techniques, ethics, communication skills (including team-working), how to teach (and learn) and management skills. Increasingly, they are accountable to standards that must be medically-led, evidence-based, and context-appropriate (UEMS guidelines). Performance monitoring must be confidential, and outcomes need to be assessed with consideration for factors contributing to variation. The latter include case-mix, and speciality, collective areas such a team-contribution, and global factors such as resources and environment. UEMS recommends monitoring at various levels: Workplace assessment through visitations, assessments, and developmental reports; Team assessment through internal and external review, and individual assessment through audit, peer-review and surveys of patients and colleagues. Medically-led accountability in conjunction with risk management in a blame-free culture should lead to better care-it is better to learn from problems to prevent recurrence. Resources required include time, people, IT, and money.Compulsory systems have not been shown to be effective, and focussing on a single area is inappropriate. UEMS has proposed that five regulatory tiers (personal, team-based, workplace, national, international) should be assessed against the quality of care functions of standards and ethics, medical education, registration and ensuring fitness to practice. The quality agenda is essential to the development of a new professionalism and good medical practice. The compulsory system developed by the UK General Medical Council for revalidation assesses the standard of medical care, doctor-patient relationships, teaching and training, team-working, probity and health, in a process linking practice, reflection, appraisal and revalidation.

**Dr Michael Wilks, Chairman, Ethics and Professional Codes Subcommittee of the CPME/Standing Committee of European Doctors** addressed **'Is the enforcement of medical ethics part of patient safety?'** Ethical practice creates trust and is the bedrock of professionalism-it can be encouraged-but it cannot be enforced. It can be assessed, appraised and validated. It can also be regulated and placed in contracts of employment, and ultimately it can be challenged, in a court of law. Good ethical practice is based upon *autonomy* (self determination),*beneficence* (professional ethos), *non–maleficence* ("first do no harm"),and *justice* (equity of access and outcome).The application of these principles in medical practice lead directly to areas relevant to patient safety such as consent, continuous professional development, consideration of net benefit, and respect for rights and appropriate resource allocation. Applying ethical principles to the relationship between doctors and society leads to further considerations of the patient's right to the highest attainable standard of health, beneficence leads to doctors' duty for political engagement, with non-maleficence requiring exposure of inequities and inequalities. Justice requires the support of evidence-based interventions. The move from paternalism to autonomy and its impact upon professional identity, with the concurrent medical 'scandals', the introduction of Human Rights law, the better teaching of ethics and the introduction of appraisal and revalidation have all impacted upon this-as have increasing consumerism. Topical medical issues including withholding end-of life treatment, organ donation, were addressed. Developments in ethics have included increasing multidisciplinary participation, enforcement though Medical Councils-and even on the European plane, the duty to share information between national regulators. The duty to protect and promote the health of patients and the public by acting quickly if you have good reason to believe that you or a colleague is not fit to practise. In recent

years, ethical standards have also been the subject of the European Human Rights Law, with a conflict between Article 2 :*"everyone's right to life shall be protected by law"* and Article 3:*"no one shall be subjected to torture or to inhuman or degrading treatment or punishment"*. A number of end-of-life judgements in the UK have illustrated varying interpretations between these two articles, resulting in conflicts as in the 'Diane Pretty' and 'Ms B' cases. Other 'civil' law challenges have included the enforcement of treatment, "Redress", and the "right" to health. The UK NHS has addressed these by introducing Mediation, the culture of openness – with protection from legal action, where the NHS provides remedial care enabling learning from past mistakes to prevent future repetitions. The right to health includes the right to health-related information, to freedom from discrimination, child health, maternal health and to access essential drugs.

**HE Prof Guido De Marco, President Emeritus of Malta and Chairman of the Commonwealth Foundation** made some concluding comments on Patient Safety and Criminal Liability, drawing upon his knowledge as Professor of Criminal law. His talk illustrating the principles and various judgements throughout the Commonwealth impacting upon this area raised a lively debate from the floor.

*The Conference then split into two parallel sessions, with Regional presentations addressing the main challenges to be faced. These are reported separately.*

**Workshop No. 1:**
**Regional Presentations: What are the main challenges to be faced?**
**Rapporteur: Dr Lisa Pullicino**

*Cyprus:* **Dr. A Dimitriou** representing Cyprus stated that patient safety is a critical aspect of patient care, emphasizing the need for concerted European efforts. In Cyprus, the Cyprus Medical Association, the Ministry of Health, the Parliament Health Committee and the patients themselves all play a role in patient safety. The Cyprus Medical Association's activities in the sphere of patient safety included providing education re: informed consent, increasing awareness on antibiotic resistance, the implementation of the CME system and the installation of automatic defibrillators. The Ministry of Health also collaborates with the WHO with regards to public health issues. Dr. Dimitriou stated that the 600 doctors working in the public sector had a much larger workload when compared to the 1400 doctors working in the private sector who provided service to only circa 20% of the population.

*Jamaica:* **Dr. EK Donaldson** presented a geographical overview of health services in Jamaica, the two main hospitals being the University Hospital West Indies and the Kingston Metropolitan Regional Hospital. Amongst the problems they face are delapidated buildings, overpopulation and understaffing, With regards to patient safety, steps are being taken to ensure an increased patient safety culture and attempts are underway to increase central regulation. eg. the University Hospital West Indies appointed a patient safety administrator.

*Malaysia*: **Dr. Krishnan** stated that the Malaysian government is in the process of setting up a safety council. Standards are also being set in clinical governance

especially with regards to the management of complaints and more funds are being allocated to research, training and education. The Malaysian health authorities are also conducting national studies about long working times of doctors in relation to patient safety. Dr. Krishnan emphazised the importance of national and international networks regarding patient safety.

*Malta*: **Dr. M Borg Buontempo** gave an overview of the Maltese healthcare situation vis a vis public and private hospitals. She also stated that the Ministry of Health participated in a working group at EU level. The main issue Malta currently faces re: patient safety are hospital acquired infections where significant rates are documented. In view of this a Hand Hygiene Campaign has been implemented this year. The Public Health Department also devised a pandemic preparedness plan according to WHO guidelines and Malta follows EU directives on the safety of blood/blood products and on organ transplantation.
As yet, there is no structure for clinical incident reporting and one of the main obstacles to this is the 'blame and shame' culture together with a fear of litigation. However, administrative enquiries do take place when an error is reported.

*UK:* **Dr. E. Borman** emphasized the importance of patient empowerment in the context of patient safety. Steps taken in the direction of patient safety in the UK were revalidation of doctors, peer reviews and internal audits and inspection at the work place. The National Patients Safety Association and the National Institute of Clinical Excellence also play an important role towards a culture of patient safety. The GMC also encourages international regulation of doctors.
A floor discussion followed, the main topic discussed being error reporting, particularly the issue of confidentiality in small countries. Dr. J. Poulsen stated that it has been shown that the more punitive a system is, the greated the tendency to cover up mistakes and the more errors are 'pushed under the carpet' emphasizing the importance of a structure for error reporting. Nurses, pharmacists and doctors actively participated in the discussion that ensued.

**Workshop No. 2:**
**Regional Presentations: What are the main challenges to be faced?**
**Rapporteur: Mr G Caruana Dingli**

There were four interesting presentations from delegates representing Nigeria, Ghana, Mauritius and India. These are very diverse countries linked by the Commonwealth and the English language but with very diverse economies and levels of health care.

**Dr Dada (middle figure)**

**Dr A Dada** described the situation in Nigeria where there is a marked maldistribution of doctors in the city compared with the countryside. This means that there is an inadequate overworked workforce with economic problems and inadequate resources.
The lack of qualified health workers leads to the proliferation of alternative practitioners leading to obvious problems. Dr Dada described specific problems. He mentioned blood transfusions where problems of finding donors and screening are compounded by basic problems with storage of the blood because of the poor infrastructure, which leads to basic problems

like the lack of clean water for scrubbing before surgery. It was interesting to hear about particular cultural beliefs. Apparently, Nigerian patients expect to receive an injection and if the doctor does not give them one, they will seek it elsewhere. This can be very dangerous!

**Dr Opoku Adusei** detailed the organization of health services, regulatory bodies and professional associations in Ghana. Ghana has quality assurance units and other systems which increase patient safety. Health care is on a 'cash and carry' basis but recently a national health insurance scheme was introduced and this has been taken up by 40%. Problems encountered include the media which misinform the public. Quacks, churches and traditional beliefs contribute to poor patient outcomes. I am sure that juju and witchcraft do not have a strong culture of patient safety!

Mauritius is the smallest of the four countries discussed. **Dr Gungah** explained that there is very good access to public health hospitals with good standards of health care. There are also private clinics. It was nice to hear that patients in Mauritius are well educated because of free schooling. They are also well aware of their rights.There is a focus on improved standards across the board e.g. laboratory, equipment, medicines etc There are also plans to set up a patient charter and redress complaints. A problem specific to Mauritius is the large number of immigrant doctors and there is a need to evaluate the standards of these immigrants. Dr Gungah also explained the problems of CPD in a small country where it is difficult to travel to conferences abroad. This is similar to the situation here in Malta.

The last country discussed was India. **Dr Arulraj** explained that 30-40 % of health care in India is free in public hospitals. The rest are treated privately and recently regulation of the private sector was introduced. The concept of patient safety is picking up. The introduction of medical tourism and medical insurance have led to increased standards of health care. Blood transfusion is stringently regulated and all blood is screened. Donors are patient relatives and care is taken in storage of blood.He also explained that there are safe injection practices and hospital waste management. He expressed concern that nosocomial infections effect 12-20% of patients.

It was Prof Reason who struck me with his comment. In poor countries struggling to provide very basic healthcare, surely patient safety is still a luxury.
A lively discussion followed the presentations.

**Workshop No.3: What could be done?**
**Rapporteur: Dr. K. Gungah**

**Dr. Nadine Delicata on WHO Draft Reporting Systems;**
Target is to develop a reporting system by all countries that could be reviewed periodically and whose core principles are:
i) Patient safe from mistake
ii) No blame to reporters
iii) Leads to constructive approach

She identified two systems:

i) Learning system, which is voluntary, fosters improvements, and covers wide scope of events.
ii) Accountability system, which is mandatory and restricted to adverse events and restricted list of events.

The advantages of the Reporting Systems are: designed to foster continuity, prevents mishaps and near misses, has a body to gather information and uses them fruitfully, non-punitive, confidential, independent of organizations which have punitive power, leads to expert analysis, is timely and system-oriented and is responsive.

**Front Row: Prof Akosa (President CMA), Dr Amuzu (Commonwealth Secretariat), Dr Arumugan (World Medical Association), Dr S Arulrhaj (incoming President CMA)**

**Dr. Robert Camilleri on The practicalities of introducing Guidelines into Clinical Practice.** According to him there is resistance to the local perspective as safety culture is not well established locally and that international guidelines have to be adapted to local needs. The precipitating factors for guidelines are mishaps and fear of court. Good Guideline is advisory but not mandatory and should be clear and specific. It is a decision-making tool and closes the gap for mishaps as in evidence-base guideline. It helps the Patients, the Health-care Providers and the Health-care Organization.
Guideline development group committee consists of the Coordinator who authorizes the Guideline Developer who draws up the guidelines and collaborates with the rest of the members of the group. It involves planning **à** peer review **à** implementation **à** evaluation **à** feedback and dissemination.
He highlighted his personal experiences in two projects he coordinated. namely the Myocardial Infarct Guideline and the Deep Vein Thrombosis Guideline. The benefits were remarkable, changing a non-uniform management characterized by lack of coordination, long distance between diagnosis investigation and treatment, reluctance on behalf of junior doctors into a fast tract triage, rapid ecg/venogram and its interpretation and treatment.

**Dr. Alex Aquilina on Safe delivery of Blood Products & Safe Production of Blood.**
Blood and its product should be of quality and he defined quality as the highest achievable, but conceded that it is not possible here. However locally there is a good donor-base and the staff is willing to change and to improve.
It is a vein-to-vein procedure and strict guidelines should be followed. The constraints are a poorly defined process and grossly inadequate premises.The lessons learnt from the later part of the 20$^{th}$ century depend on people's awareness, political awareness and fund.
The requirements are documentation, implementation and maintain continually improved effectiveness.

He stressed that quality is the responsibility of everybody and that quality of products depends on equipment and well-defined procedures.

**Dr. Stefan Laspina on Safe delivery of Blood Products & Safe Production of Blood.**

He stressed the importance of transmitting diseases through blood transfusion like haemophilia, HIV etc. Blood Transfusion is a transplant of cell and hence its accompanying and inherent risks. Potential complication is death and many deaths have been registered.

Haemovigilance should be maintained in order to collect data on adverse effects of Blood and Blood products transfusion. Few examples from other countries are: Ireland 1.5/1000,UK: 1/10000,Denmark: 4.5/100000.It is important that data collection should be on a uniform basis. The fear of transmitting virus through blood transfusion is high, but he showed that adverse effects of wrong blood transfusion is great at 71.5% compared to virus at 1-2%. Great vigilance and care should be maintained during Blood and Blood Products transfusion and hand held electronic devices or any other forms of devices can help to prevent errors.Guidelines are very important. They can be formulated by the Hospital Transfusion Committee (HTC) which coordinates the activities of the Safe Practice committee, Clinical Practice committee, Audit committee and the Education & Training committee. The HTC reviews guidelines and haemovigilance.

***The Final session closed with a global overview of the workshop summaries. It was formally closed by the Hon Min of Health, the Elderly and the Community, Dr L Deguara and Prof Akosa, President of the Commonwealth Medical Association.***

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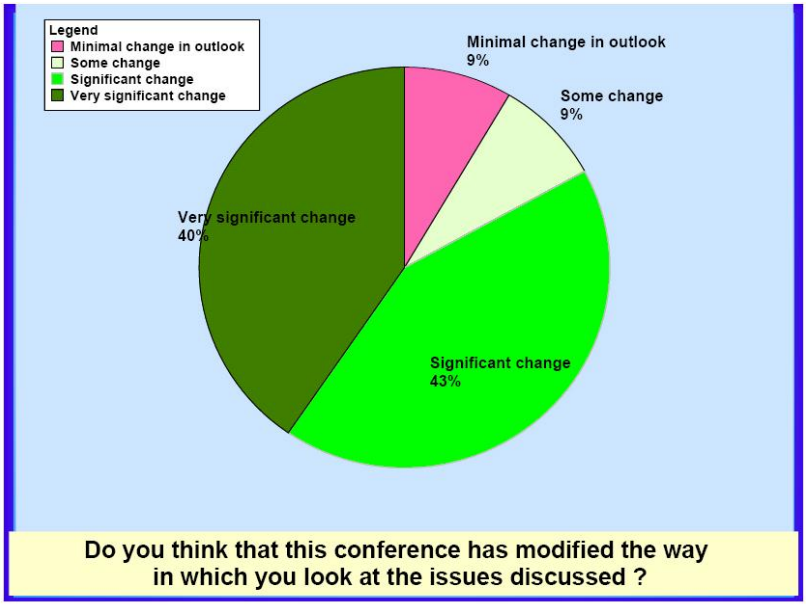
A sample from the overall conference evaluation is reproduced below.




**Evaluation: Success in our declared aims!**

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