



World Patient Safety Day 2024



Contents

3. Introduction

4. Surgeons' News – September 2024 Edition

5-7. Blogs and Features

8-12. WPSD Infographics

13. Webinar - Healthcare Safety & Quality in the US: Perspective from Time Leading a National Organisation

14-16. Series of Vignettes

The RCSEd would like to extend our gratitude to everyone who kindly contributed to our World Patient Safety Day (WPSD) 2024 Campaign.

Upholding patient safety and ensuring the highest standards of patient care are core values of the College and at the heart of all the work the College undertakes. Patient safety is embedded in the rigorous professional standards that run through all our educational, examination and audit activities. The College works hard to improve safety for patients, for surgeons, for teams, for organisations - for all.

The following includes added links to view all the content and features that were included in the promotion of The RCSEd WPSD 2024 communications.

Thank you for supporting our WPSD 2024 Campaign!

Surgeons' News

September Edition

World Patient Safety Day –
and how does it affect you.

10 page feature on patient safety

[CLICK HERE](#) to view!





Blogs and Features.

WHO World Patient Safety Day 2024: Improving Diagnosis for Patient Safety' by Anna Paisley, Consultant General Surgeon, RCSEd Council Member and Patient Safety Group Chair. [CLICK HERE](#) to view.

'Diagnostic Safety in Surgery' by Anna Paisley, Consultant General Surgeon, RCSEd Council Member and Patient Safety Group Chair. [CLICK HERE](#) to view.

'The Importance of Teamwork for Surgical Diagnostic Safety in Outpatients' by Andrew D Martindale MA BM BCh FRCSEd (Urol.) Consultant Urological Surgeon NHS Tayside, RSA East Scotland and Educational Tutor, RCSEd. [CLICK HERE](#) to view.

'The potential of AI to help reduce diagnostic errors' Afra Jiwa, PhD Student, Centre for Medical Informatics, Usher Institute, University of Edinburgh and Malcolm Cameron, Research Assistant, , Centre for Medical Informatics, Usher Institute, University of Edinburgh. [CLICK HERE](#) to view.

'Virtual diagnostics' by Afra Jiwa, PhD Student, Centre for Medical Informatics, Usher Institute, University of Edinburgh and Malcolm Cameron, Research Assistant, Centre for Medical Informatics, Usher Institute, University of Edinburgh. [CLICK HERE](#) to view.

'Improving Diagnosis for Safety in Dentistry' by Claire Morgan. Deputy Chair for Patient Safety Group and Dental Council RCSEd Consultant in Restorative Dentistry, Patient Safety Specialist Barts Health Trust. [CLICK HERE](#) to view.

Blogs and Features.

‘Can my stool be tested for bowel cancer?’ by Prateek Arora . MS, MRCS, DNB , DrNB Surgical Gastro, Senior Clinical Fellow , Colorectal and Peritoneal Oncology Unit, Christie NHS and CR Selvasekar MD. FRCSEd (Gen), MFSTEd, MA (Clin Ed), MBA (Health Executive). [CLICK HERE to view.](#)

‘A View from the Bridge’ by Chris McEwan. Lay Representative on RCSEd Patient Safety Committee. [CLICK HERE to view.](#)

‘Diagnosing Acute Aortic Dissection – The Patient Perspective’ by Gareth Owens, MSc.(Oxon), MBCS, CITP, Aortic Dissection Survivor, Chair, Aortic Dissection Awareness UK & Ireland. Global THINK AORTA Campaign Lead. [CLICK HERE to view.](#)

‘Protecting your precious gift of life’ by Dr Sumita Barua. Heart Transplant Fellow, Queen Elizabeth Hospital Birmingham UK and Mr Majid Mukadam FRCS(C-Th) MCh(CVTS) PGCE(UoB). Associate Specialist (Surgeon) – Cardiothoracic Transplantation. Queen Elizabeth Hospital Birmingham UK. [CLICK HERE to view.](#)

‘NCEPOD: Prioritising Diagnostic Safety for Better Health Outcomes’ by Martin Sinclair, NCEPOD Surgical Clinical Co-ordinator, on behalf of NCEPOD. [CLICK HERE to view.](#)

‘A Novel Facial Cellulitis pathway; Improving the time to surgery for Facial Necrotising Fasciitis’ by Mr Peter Steele, Consultant OMFS/ Head & neck Surgeon. [CLICK HERE to view.](#)



Blogs and Features.

‘Diagnostic Safety in Otolaryngology-Head and Neck surgery’ by Nashreen Oozeer, Head and Neck cancer Surgeon based at South Tyneside and Sunderland NHS trust, northeast of England. Deputy chair for the RCSEd Otolaryngology SSB. Lead for ENTUK Patient information project and the ENT UK co-lead for robotics. [CLICK HERE to view.](#)

‘Improving Diagnostic Safety in Orthopaedics’ by Professor Neil Ashwood. Consultant Trauma and Orthopaedic Surgeon. University Hospitals of Derby and Burton. [CLICK HERE to view.](#)

‘Enhancing Diagnostic Safety in Surgery Through Non-Technical Skills’ by Professor Steven Yule. Chair of Behavioural Sciences, University of Edinburgh Director, Surgical Sabermetrics Laboratory, Usher Institute, University of Edinburgh. Director of Non-Technical Skills Faculty, Royal College of Surgeons of Edinburgh and the Non-Technical Skills for Surgeons (NOTSS) Committee. [CLICK HERE to view.](#)

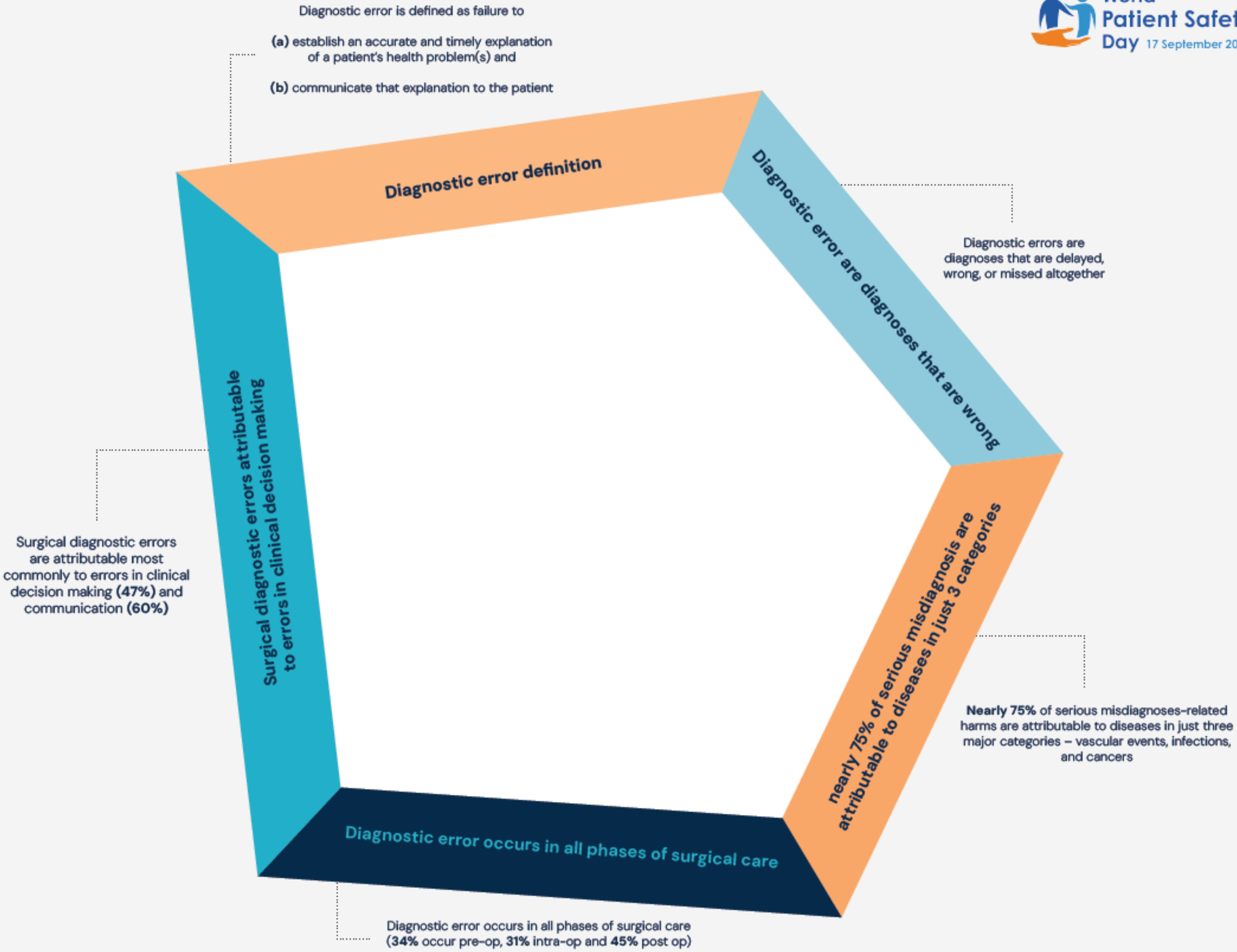
‘Challenges in the diagnosis of twin silent killers: aortic aneurysm and acute aortic dissection’ by R. Weerakkody, Consultant Vascular Surgeon and A.L. Tambyraja, Consultant Vascular Surgeon. [CLICK HERE to view.](#)

'Using audit to improve outcomes for patients with Upper Tract Urothelial Cancer' by Mr Alexander Laird PhD FRCSEd (Urol). Consultant Urological Surgeon and Honorary Clinical Senior Lecturer. Department of Urology. The University of Edinburgh. [CLICK HERE to view.](#)

WPSD Infographic 1 – Diagnostic Error.



Diagnostic error



WPSD Infographic 2 – Scale of the Problem.



The scale of the problem



diagnostic errors accounts for **16%** of preventable harm that arises in healthcare globally



most people will experience at least **one diagnostic error** in their lifetime



10-15% of all diagnoses are erroneous



diagnostic errors account for **22%** of paid malpractice claims in acute care



diagnostic errors remain the **most common**, most catastrophic, and most costly of serious medical errors in closed malpractice claims



over 50% of patients involved in surgical error experience at least moderate harm, and this is fatal in 1 in 7



misdiagnosis accounts for up to **80,000 deaths** and **16,000 serious harms** in US hospitals annually



8% of adverse events in medicine are related to harmful diagnostic errors



14% of adverse events in hospitalized patients are related to harmful diagnostic errors



diagnostic error occurs in **4%** of primary care consultations



diagnostic error occurs in **5%** of outpatient consultations



diagnostic error occurs in **0.7%** of adult hospitalizations



diagnostic error occurs in **7%** of patients transferred to intensive care



diagnostic error occurs in **30%** of Accident & Emergency patients



diagnostic error occurs in **6%** of medical 7-day readmissions

WPSD Infographic 3 – Cause of the Problem.



Cause of the problem



WPSD Infographic 4 – Solutions.



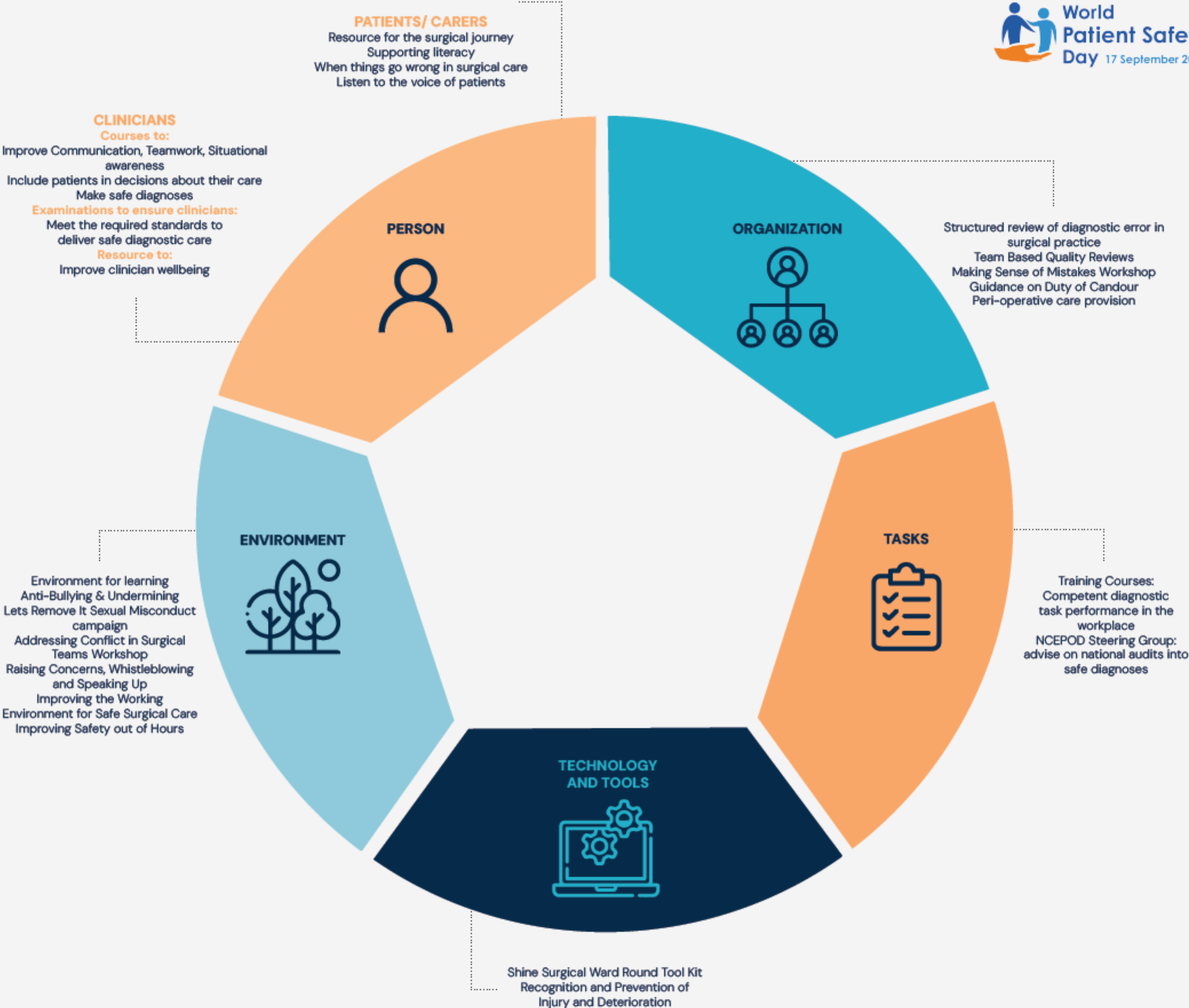
Solutions



WPSD Infographic 5 – How can RCSEd Help.



How the RCSEd can help



Webinar.

Healthcare Safety & Quality in the US: Perspective from Time Leading a National Organisation

17th September 2024, 18:00 to 19:00 GMT .

Overview

This webinar will give an overview of the safety & quality scene in the US with a focus on accreditation and regulation of healthcare organisations.

Aims and Learning Objectives

By the end of this webinar, attendees should be able to:

- Understand the regulatory and accreditation world of healthcare in the US
- Have a glimpse at the patient safety challenges faced in the US
- Understand diagnostic errors and bias in healthcare

This will be available post-webinar for RCSEd Members to view at convenience on the RCSEd website, archived webinars section by [CLICKING HERE.](#)

Vignette 1. [CLICK HERE](#) to view.

World Patient Safety Day

**Non-Technical Skills for Surgeons (NOTSS).
Vignette 1 of 3.**

Situation Awareness: Staying Ahead of Potential Issues.



Vignette 2. [CLICK HERE](#) to view.

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**Non-Technical Skills for Surgeons (NOTSS).
Vignette 2 of 3.**

Team Communication: The Key to Clarity and Precision.



Vignette 3. [CLICK HERE](#) to view.

World Patient Safety Day

**Non-Technical Skills for Surgeons (NOTSS).
Vignette 3 of 3.**

Leadership in Surgery: A Case Study.



Thank You