Day 1

Time					Topic	Instructor
Maldives	Johannesburg/ Geneva	Colombo	Bangkok	Tokyo		
15:00 – 15:10	12:00 – 12:10	15:30 – 15:40	17:00 – 17:10	19:00 – 19:10	Welcome & overview	WHO
15:10 – 16:00	12:10 – 13:00	15:40 – 16:30	17:10 – 18:00	19:10 – 20:00	**1.1 Introduction of patient safety** 1.1.1 Classification of hospital accidents 1.1.2 Types of Medical errors 1.1.3 Elements of safety culture 1.1.4 Evolution of patient safety culture 1.1.5 No-blame culture	Dr Sri
16:00 – 16:50	13:00 – 13:50	16:30 – 17:20	18:00 – 18:50	20:00 – 20:50	**1.2 Introduction of the patient safety incident reporting and learning systems** 1.2.1 What is PSI RLS? 1.2.2 Key definitions and concepts of patient safety incident 1.2.3 Different requirements of different levels of PSI RLS (institution, sub-national, national) 1.2.4 Linkage with ICD 11 (if possible)	Ms Ronel
16:50 – 17:00	13:50 – 14:00	17:20 – 17:30	18:50 – 19:00	20:50 – 21:00	Break	
17:00 – 18:00	14:00 – 15:00	17:30 – 18:30	19:00 – 20:00	21:00 – 22:00	**1.3 Knowledge on the creation of a safe environment for health workers to report patient safety incidents** 1.3.1 Understanding of "To Err is Human" 1.3.2 Non-punitive investigation, confidentiality 1.3.3 Facilitation of reporting by such measures as no-blame culture/Anonymous reporting, production of list of events to report, cooperative reporting i.e. reporting not only by a single person but by a multiple person who are aware of the event etc.	Dr Shin

Day 2

Time					Topic	Instructor
Maldives	Johannesburg/ Geneva	Colombo	Bangkok	Tokyo		
15:00 – 16:00	12:00 – 13:00	15:30 – 16:30	17:00 – 18:00	19:00 – 20:00	**2.1 Understanding of the existing environment for PSL RLS** 2.1.1 Existing national adverse event systems 2.1.2 Existing legal environment (i.e., Cerebral palsy compensation)	Dr Shin
16:00 – 16:10	13:00 – 13:10	16:30 – 16:40	18:00 – 18:10	20:00 – 20:10	Break	
16:10 – 17:00	13:10 – 14:00	16:40 – 17:30	18:10 – 19:00	20:10 – 21:00	**2.2 Understanding of the operationalization of PSI RLS** 2.2.1 Staffing 2.2.2 Training 2.2.3 Management of PSI RLS	Dr Sri
17:00 – 17:10	14:00 – 14:10	17:30 – 17:40	19:00 – 19:10	21:00 – 21:10	Break	
17:10 – 18:00	14:10 – 15:00	17:40 – 18:30	19:10 – 20:00	21:10 – 22:00	**2.3 Challenges** How to facilitate reporting to avoid suffering under reporting? etc **Sri Lanka's experience**	Dr Sri

Day 3

Time					Topic	Instructor
Maldives	Johannesburg/ Geneva	Colombo	Bangkok	Tokyo		
15:00 – 16:00	12:00 – 13:00	15:30 – 16:30	17:00 – 18:00	19:00 – 20:00	**3.1 Understanding the application of Incident reports** 3.1.1 Main purpose of collecting incident reports 3.1.2 What data elements to be collected (Minimal Information Model for Patient Safety, etc) 3.1.3 How to collect data 3.1.4 How to assess the quality of data/incident reports Terms of reference of Quality assuarance manager in South Africa (TBC) **South Africa's experience**	Ms Ronel
16:00 – 16:10	13:00 – 13:10	16:30 – 16:40	18:00 – 18:10	20:00 – 20:10	Break	
16:10 – 17:00	13:10 – 14:00	16:40 – 17:30	18:10 – 19:00	20:10 – 21:00	**3.1 Understanding the application of Incident reports** 3.1.5 Importance of data analysis 3.1.6 How to use data (short-, mid-, long-term implications) 3.1.7 What types of product* are produced through reporting and learning system? (quarterly report, annual report, monthly alert, database, etc at institution and national levels) 3.1.8 How the product of reporting and learning system is useful in healthcare delivery.	Dr Shin
17:00 – 17:10	14:00 – 14:10	17:30 – 17:40	19:00 – 19:10	21:00 – 21:10	Break	
17:10 – 17:30	14:10 – 14:30	17:40 – 18:00	19:10 – 19:30	21:10 – 21:30	**Thailand's experience**	Dr Piyawan
17:30 – 18:00	14:30 – 15:00	18:00 – 18:30	19:30 – 20:00	21:30 – 22:00	**Discussion and wrap up**	All, WHO

Male	Geneva	Johannesburg	Colombo	Bangkok	Tokyo
Mon 15:00	Mon 12:00 *	Mon 12:00	Mon 15:30	Mon 17:00	Mon 19:00
Mon 16:00	Mon 13:00 *	Mon 13:00	Mon 16:30	Mon 18:00	Mon 20:00
Mon 17:00	Mon 14:00 *	Mon 14:00	Mon 17:30	Mon 19:00	Mon 21:00
Mon 18:00	Mon 15:00 *	Mon 15:00	Mon 18:30	Mon 20:00	Mon 22:00
Mon 19:00	Mon 16:00 *	Mon 16:00	Mon 19:30	Mon 21:00	Mon 23:00

Patient Safety Incident Reporting and Learning Systems Training for the Maldives

Instructors' information and WHO references

1. Training instructors

Four international experts will facilitate the sessions in 3 days.

Name	Country	Role
Dr. Piyawan Limpanyalert	Thailand	Chief Executive Officer, Hospital Accreditation Institute
Dr. Sathasivam Sridharan	Sri Lanka	Deputy Director-General, Planning Ministry of Health
Ms. Ronel Steinhobel	South Africa	Directorate, Quality Assurance Ministry of Health
Dr. Shin Ushiro	Japan	Professor, Division of Patient Safety, Kyushu University Hospital Executive board member, Japan Council for Quality Health Care (JQ) Advisor to the Minister on Global Patient Safety Action, Ministry of Health, Labour and Welfare

2. WHO publications on patient safety incident reporting and learning systems

WHO published a series of publications on patient safety incident reporting and learning systems.

- Patient safety incident reporting and learning systems: technical report and guidance (2020)
  This new guidance builds on the WHO draft guidelines for adverse event reporting and learning systems: from information to action.
- Minimal Information Model User Guide (2018)
  This user guide explains each element in Minimal Information Models for Patient Safety (MIM PS) and the difference between the basic model and the advanced model of MIM PS
- EU validation of a minimal information model for patient safety incident reporting and learning systems: executive summary (2018)
  This report summarizes how the MIM PS was developed with European Commission and WHO
- The conceptual framework for the international classification for patient safety (2009)
  This publication shows the conceptual framework of the international classification for patient safety (ICPS)
- The draft guidelines for adverse event reporting and learning systems: from information to action (2005)
  Very first guidance on the establishment of PSI RLS