Dialogue Summary

Addressing Medical Errors in the Lebanese Healthcare System

K2P Policy Dialogue convenes key policymakers and stakeholders to capture contextual information, tacit knowledge, views and experiences including potential options to address high priority issues.

K2P Policy Dialogues are informed by a pre-circulated K2P Policy Brief or Briefing Note to allow for focused discussion among policymakers and stakeholders.

Dialogue Summary

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K2P Dialogue Summary

Addressing Medical Errors in the Lebanese Healthcare System

Knowledge to Policy Center K2P

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Dialogue
The policy dialogue about Addressing Medical Errors in the Lebanese Healthcare System was held on February 5, 2016 at the Gefinor Rotana Hotel, Beirut, Lebanon. The policy dialogue was facilitated by Dr. Fadi El-Jardali, the director of the K2P Center.

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Preamble

The K2P Policy Dialogue, conducted on February 5, 2016, was attended by diverse stakeholders: representatives from the Ministry of Public Health (MOPH), representatives from different orders and syndicates (Syndicate of Private Hospitals, Order of Physicians, Order of Nurses and Order of Pharmacists), hospital managers, representatives from international agencies (such as the World Health Organization and the Red Cross) and national agencies and programs, representatives from Primary Healthcare Centers and insurance companies, as well as researchers and public health scholars. The policy dialogue hosted 23 people and was facilitated by Dr. Fadi El-Jardali, the Director of the K2P, with the presence of Dr. Walid Ammar, the Director General of the MoPH.

Deliberations about the problem

Dialogue participants discussed the overall framing of the issue of medical errors in the Lebanese healthcare system. All participants endorsed the existence of the problem and agreed about the need to focus on the many factors that are leading to the problem.

Most participants agreed that reporting done by patients and their families on medical errors and adverse events to the MoPH and Order of Physicians has been increasing. This rise is mostly due to the role media is playing in increasing patients' awareness on medical errors. However, participants also specified that this increase might not reflect the actual number of incidents occurring, since adverse events reported might be due to medical complications or other reasons that are not related to preventable medical errors.

Participants agreed that the data on actual incidence of medical errors in Lebanon is still unknown. This is due to the underreporting of adverse events, medical

Background to the Policy Dialogue

The Policy dialogue was convened in order to support a full discussion of relevant considerations (including research evidence) about a high-priority issue in order to inform action.

Key features of the dialogue were:

1) Addressing an issue currently being faced in Lebanon;
2) Focus on different underlying factors of the problem;
3) Focus on four elements of an approach for addressing the policy issue;
4) Informed by a pre-circulated K2P policy brief that synthesized both global and local research evidence about the problem, elements and key implementation considerations;
5) Informed by a discussion about the full range of factors that can inform how to approach the problem and possible elements of an approach for addressing it;
6) Brought together many parties who would be involved in or affected by future decisions related to the issue;
7) Ensured fair representation among policymakers, stakeholders, and researchers;
8) Engaged a facilitator to assist with the deliberations;
9) Allowed for frank, off-the-record deliberations by following the Chatham House rule: "Participants are free to use the information received during the meeting, but neither the identity nor the affiliation of the speaker(s), nor that of any other participant, may be revealed"; and
10) Did not aim for consensus. Participants' views and experiences and the tacit knowledge they brought to the issues at hand formed key input to the dialogue. The dialogue was designed to spark insights that can only come about when all of those who will be involved in or affected by future decisions about the issue can work through it together. The dialogue was also designed to generate action by those who participate in the dialogue and by those who review the dialogue summary.

errors and near misses by healthcare organizations and practitioners.

Some participants pointed out that reporting focuses mostly on accusations, especially of physicians. Once self-reporting (by healthcare providers) is properly implemented, a systematic and scientific approach can be taken to investigate incidents.

Based on the deliberation, the factors affecting medical errors and limiting improvement of the current situation are: 1) the lack of repository systems from which incidence of medical errors and near misses can be determined, 2) the lack of a national anonymous system for reporting errors and near misses, 3) and a safety culture (that allows reporting, learning, sharing, having a just culture and accountability) that is still not instilled in the day to day activities.

The subsequent deliberations focused on the fact that whenever an adverse event occurs it can be solved at three different levels:

- At the patient-physician level: clear communication and disclosure between physicians and patients, helps reduce errors and resolve misunderstandings related to medical complications and errors. However, even if the problem is resolved at this level, there still remains a need to develop a national or organizational reporting system.
- At the patient-healthcare organization level: patients can report incidents and other concerns to the organization's management. In this case, the management directly takes care of and solves the issue/complaint.
- At the patient-higher authority level: patients report incidents to the Order of Physicians or the MoPH, which will be in charge of the investigation.

Participants noted that at all three levels a non-punitive environment should be present. They also concurred that the aim of reporting is to create a learning culture to improve, prevent similar errors in the future, and provide patients with their rights.

Some participants focused on the need to hold healthcare providers accountable for errors. Providers tend to become defensive instead of taking advantage of the error to learn and improve care provided. Participants agreed that, to reduce errors, there should be joint responsibility between healthcare organizations and providers.

Pro-active and preventable measures should be taken by all entities involved to control and reduce the number of medical errors and adverse events.

Some participant stated that since medical errors' investigation process is long and the verdict takes time to be determined, there is a need to set a system that specifies which types of errors should be reported. This can be done through assessment of reported errors, to identify which should be sent for further investigation and which not.

Deliberations also tackled media and its role in reporting news related to medical errors and patient safety. All participants agreed that in many instances media is playing a negative role when it comes to reporting medical errors. It was noted that media does not always report news in a scientific manner, and is not being able to differentiate between preventable medical errors and medical complications. Most participants mentioned that media in some cases is disrupting people's trust in the healthcare system. It was also mentioned that media is sometimes ill-informed and might create conflict, instead of encouraging collaboration between the different parties. In addition, media is unaware of the patient safety improvements that have been going on in the past 15 years. Hence, the news is not reporting on how the Lebanese healthcare system has been evolving and improving throughout the years. Some participants commented on the latter and mentioned that although there have been improvements; no benchmarks have been developed to track them.

Participants however, noted that if media is well informed, reporting news about medical errors and adverse events can help bring improvements into the current healthcare system. Also, scientific reporting of news can enhance public's awareness and allow media to report facts instead of jumping into conclusions.

Governance Arrangements

Most participants agreed that there is a need to empower parties other than the MoPH. It was suggested that the role of the Syndicate of Hospitals, Order of Physicians, Order of Nurses and Order of Pharmacists should be strengthened. There is a need for syndicates and orders to become more active to meet and implement the existing national policies. It was mentioned that when national policies are developed syndicates and orders representatives' opinions are taken

into consideration, however, not all syndicates and orders are equally active in the development and implementation of policies. In addition, it was mentioned that during implementation the absence of a strategic direction that sets out tasks, weakens coordination between the different parties and makes the process difficult and less successful. Therefore, it was suggested to form a national committee that coordinates work between different parties, makes sure all parties know what their and other parties' responsibilities are, and investigates medical errors.

Few participants also mentioned that there is a need for syndicates and orders to support and maintain certifications of providers that are solely provided by the MoPH. Therefore, it is important to develop national guidelines for practices that syndicates can refer to.

One participant mentioned that whenever a new president is elected at a syndicate or order, most processes and procedures are changed, and instead of having continuity of work, a lot is being re-done from zero. This is affecting and limiting the role of syndicates and orders.

Initiatives to improve the current quality of care and role of the Orders of Physicians were taken. These include three draft laws that were submitted to the parliament. The drafts are still not executed and include: amending the process of licensing physicians (decree 1658), developing a Lebanese Board (decree 1658), and re-evaluating the role and responsibilities of the Orders of Physicians (law 313).

The draft law that re-evaluates licensing of physicians, amends the existing decree number 1658 related to regulating medical practice of physicians. The draft adds the following two conditions: 1) physicians need to hold a medical degree from a university recognized by the Ministry of Education and Higher Education (MEHE), 2) physicians need to pass a written exam followed by an oral and clinical exam. If these two are met along with the other pre-existing conditions, such as holding a baccalaureate degree recognized by MEHE and having no criminal record, the physician can obtain a license to practice in Lebanese healthcare organizations.

The draft law about creating a Lebanese Board, states the need to develop an independent entity under both Orders of Physicians (Beirut and Tripoli). This new entity, aims at keeping up with medical advancements, through improving medical education and medical specialization in Lebanon. The draft law identifies the Board's role:

regulating and accrediting medical school and residency (specialization) programs, setting CME standards for each medical specialty, improving the colloquium examination, conducting and monitoring Board examinations for the different medical specialties, and being involved in planning for training programs of healthcare providers.

The third draft law consists of amending law 313 that is related to founding the Orders of Physicians. The draft re-evaluates the roles of the orders, the role of the committee that provides CME and proper crediting of CME, and tackles the issue of work ethics and creating a disciplinary committee.

Deliberations raised concerns about the lack of specific indicators and benchmarks in the current accreditation system. Participants also pointed out the limited number of experts and trained personnel available to conduct audits. Also, they mentioned their doubts regarding the MoPH's capacity to regularly audit and maintain the accreditation system.

Another concern was that of healthcare professionals' tendency to forget fighting for patients' rights. This task became the role of the MoPH, since most patients reach out to the ministry whenever an error occurs. Also, there is a need for healthcare professionals in general, to be held accountable of their responsibilities.

Financing Arrangements

It was mentioned by some participants that financing of healthcare by the MoPH is decreasing. This is due to the limited national health spending. And therefore assessment of the situation is needed to understand the causes behind this issue.

Participants recognized the need to integrate indicators within the accreditation system. These should be set by the national accreditation system, as a tool for reimbursement of organizations that are complying with indicators.

After sharing high quality evidence and examples about pay for performance as a reimbursement method for healthcare organizations, participants agreed that this tool can be used to link financing to indicators. However, some acknowledged the mixed evidence available on pay for performance's effectiveness.

There was also agreement, about the need for healthcare organizations to provide measures and outcomes of their practices for

financing purposes. These can also be used for benchmarking and inter-organizations learning purposes.

Delivery Arrangements

Problems in the delivery of care, as mentioned by some participants, include: lack of systematic structures within organizations, and the weak interaction and communication between multi-disciplinary teams within organizations. It was stated that the latter is affected by the inconsistent and incomplete medical records that need to be enhanced.

Participants disagreed with the evidence about patient safety culture, punitive versus non-punitive environments and training of providers being problems, and agreed that these are rather ongoing improvements. The major challenges however, lie in the shortage of staff, especially that of nurses, and the shortage of clinical beds in emergency departments and operating rooms. To identify the reasons behind these shortages it was suggested to conduct root-cause analyses. Another participant added that shortages are also affecting resources, including hospital equipment and equipment used for patient transportation.

Deliberations about healthcare professionals' education, pointed out the importance of having continuous education of providers, and concluded that:

- There is a need to educate providers on how to accurately complete medical records for better documentation and investigation of medical errors.
- There is a need to follow up on education, since it was mentioned that "we teach but we don't do", and that providers are "taught what to do but not how to do".
- Continuing Medical Education (CME) credits should be given more importance.
- Providing incentives (monetary, credits or others) might be an option to encourage providers to attend CMEs and other educational activities.

Deliberations also pointed out gaps in the national emergency management system and pre-hospital care that need to be

addressed. It was noted by some participants that emergency physicians are few and require better more frequent trainings.

Participants mentioned few of the major problems the Red Cross faces when transporting patient to hospitals, these include: the patient requiring to go to specific hospital, the mandate that obliges the Red Cross to admit patient to the nearest most suitable hospital, while there are no criteria that specify which are the most suitable hospitals, and hospitals refusal to admit patients. One participant commented on the latter and specified that the latest ICU occupancy rate calculated in Lebanon is 95%, while older surveys from 2012 revealed that hospital occupancy rate is 65% with more than 80% in the ICU. Therefore, there is a need to re-evaluate pre-hospital care to prevent and reduce medical errors.

Some participants suggested integrating a single patient ID to manage pre-hospital care and achieve continuity of care. The ID is shared by all healthcare organizations to reduce errors that mostly occur during hand-offs and transitions.

Most participants added that there is an issue related to the scope of practice of healthcare providers. Different providers are unaware of each other's role and the importance of each one's role in the delivery of care, which needs to be addressed to enhance the delivery of care.

Deliberations

Deliberations about Elements of a Policy Approach for Addressing the Problem

Dialogue participants discussed four elements that have been examined in the policy brief.

Element 1›Enhance clinical governance through the integration of evidence-based clinical guidelines, education and training of providers, and conducting audits and performance appraisals

It was suggested to develop a national council on clinical governance. The council will be composed of members from different disciplines and different organizations. This council can further be divided into different committees each taking care of the following clinical governance responsibilities: the development of evidence-based guidelines, implementation of education and training of healthcare providers, audit and feedback and performance appraisal.

After providing evidence related to the effectiveness of evidence-based guidelines in increasing the quality of care by significantly improving skills, knowledge and attitudes of providers, it was suggested that the evidence-based clinical guidelines committee should be responsible of developing evidence-based clinical guidelines adapted to the Lebanese context. Academic institutions can provide their services to help the MoPH adapt international guidelines into the Lebanese context, since most guidelines are taken from the WHO or other international public health practices.

After deliberating about developing and implementing evidence based-clinical guidelines, it was agreed that even if guidelines are not developed at a national level, it is necessary that they are developed, agreed upon and implemented at the organizational level. This could be the first step towards developing national evidence-based guidelines.

Suggestions to make the implementation of clinical guidelines easier were provided. Various participants recommended that if national guidelines can be developed and implemented, it might

be good to provide different options for the same procedure, to ease implementation for different organizations. Another idea was to involve physicians and other healthcare providers in the development of national guidelines; this will encourages them to implement them. Also, to make implementation easier it was suggested to develop check lists that allow providers to follow standing orders and standardized steps when conducting specific procedures. The previous experience of the MoPH in developing guidelines for Primary Healthcare Centers, can as well be used as a reference to develop upcoming guidelines.

Deliberations about education, training and performance appraisal, pointed out that these are part of the national accreditation requirements, however, there are no available indications on how to perform and implement them. Some participants acknowledged the need to consider the current context and culture while implementing training and performance appraisal to make their implementation successful.

The importance of CME was mentioned again, participants agreed that CME improves physicians' knowledge, attitudes, behaviors and performances as well as patient health outcomes. Ideas about the need for syndicates to be involved in providing CME and the need for CME to be credited in a proper manner were emphasized.

Participants agreed about integrating patient safety education into curriculum of healthcare providers. This was backed up by high quality evidence that shows that such curricula enhance quality of care.

It was noted by some participants that basic life support alone is enough to save lives. Thus, it is important to provide first aid trainings to all healthcare providers. However, there is a need to assess the outcomes of the training, especially that some organizations lack the resources needed and might need to adapt trainings accordingly. One participant mentioned that life support training was provided to some nurses and physicians, but is still not well implemented.

Therefore, the role of the education and training committee should ensure appropriate implementation of clinical guidelines through training of professionals, to develop curricula of providers that integrate patient safety concepts, and to facilitate the implementation of CME and monitor its effectiveness. The latter can be done along with healthcare organizations, the different syndicates and orders and the MoPH.

Sharing high quality evidence on the effectiveness of audit and feedback and performance appraisals resulted in common agreement about the need to integrate them into the day to day practices. Hence, the committees responsible for audit and feedback and performance appraisal should ensure monitoring and evaluation are performed correctly and regularly, to achieve continuous performance improvement. Most participants agreed about the need to share best practices with different hospitals to learn from one another. It was also proposed to implement peer-review auditing, that can be managed by the audit and feedback committee, so that different healthcare organizations learn from one another and improve their performance accordingly.

In order to make this project successful, the need to develop a culture that endorses patient safety was noted.

Element 2› Develop and implement policies that promote anonymous incident reporting at the organizational and national level.

Most participants agreed about the importance to implement a national incident reporting system. Some participants however, disagreed with the fact that the reporting system should be anonymous, and stressed that providers should be held accountable of their errors. Nevertheless, participants agreed that a non-punitive environment should be integrated into organizations' culture, while acknowledging that there is mixed evidence on its effectiveness. The concept of a "just culture" was mentioned by many participants as well. Yet, to integrate such environments into Lebanese organizations, providers' culture should be taken into account.

Participants proposed that national reporting should be voluntary. This will further encourage providers to report on errors, near misses and adverse. It was also highlighted that the main aim for voluntary reporting is to create a learning environment from shared experiences.

When the facilitator shared the example of the national reporting system in Malaysia, many participants agreed that before reporting anonymously on a national level, reporting at the organizational level should be done in a non-anonymous way to be able to investigate and follow up on the reported incident and take corrective measures. Once the loop is closed within the organization the error can

then be reported anonymously on a national level to the MoPH. The latter can follow up and provide feedback to organizations for improvement, especially when errors are system related. Others added that reporting can further be used for research purposes and benchmarking.

Challenges to implement this element were discussed. First, providers find it difficult to admit doing an error whenever an incident occurs; this is mainly due to culture. Second, the Lebanese call for medical ethics, which encourages physicians to cover for each other is also a barrier for reporting. Third, the legal system, which plays a role whenever errors or adverse events occur, makes anonymous reporting and focusing on a learning environment difficult to implement. And fourth, the limited number of lawyers specialized in medico-legal subjects, makes legal investigation harder to achieve in a professional and just manner.

The Lebanese punitive action taken to penalize physicians that commit a medical error was criticized by many participants. The fact that their license to practice in Lebanon is taken away from them, while they can still practice in other countries of the region is unethical and needs to be addressed.

While deliberations about element 2 were taking place, the role of media was brought up once again. Participants mentioned the need for media to educate the public about errors and make them aware that there is always possibility for medical complications to occur.

Element 3› Revise and update current accreditation systems to ensure patient safety goals, indicators and training requirement are explicit in the standards and integrated in the contractual arrangements.

All participants agreed that the accreditation system in place needs to be revised and updated. It was mentioned that the MoPH is currently working on the renewal of the accreditation system, including the standards. Participants insisted on integrating patient safety concepts into the different accreditation standards of the new system. They also agreed that accreditation systems are important to: promote change and professional development, increase staff engagement and communication, improve organizational efficiency, encourage multidisciplinary team building, promote positive changes in organizational culture, and enhance leadership and staff awareness

about continuous quality improvement, as stated by the evidence found in several systematic reviews.

Deliberations about this element focused on the need to frequently audit the implementation of accreditation standards. As suggested by most participants, the accreditation cycle should be 3 years. Some participants mentioned the importance of performing unannounced "mock" audits as well.

After sharing high quality evidence about the effectiveness of integrating performance indicators within accreditation systems, most participants agreed about the necessity to use indicators as part of the auditing and accreditation system to be able to improve patient safety practices in healthcare organizations.

Linking accreditation status to public funding, preferential reimbursement, health insurance benefits and contractual agreements was also found to be essential for financing purposes.

One participant also suggested the integration of training on first aid to all providers into the new accreditation system to be able to reduce errors at the pre-hospital care level.

Element 4› Empower patients to enhance quality of care and patient safety.

All participants agreed about the necessity to empower patients. Some mentioned that culture acts as a main barrier and discourages patients to approach physicians.

Patient empowerment is important since it enhances shared decision-making, healthcare organizations' performance and patient safety. Therefore, it should be implemented, as a start, within healthcare organizations and with the help of local agencies. Participants suggested ways to implement patient empowerment through the following:

- Creating a patient-centered committee
- Creating patient associations
- Developing patient education material
- Developing a performance appraisal matrix that encourages physicians to educate patients
- Conducting patient awareness campaigns
- Using informed consents to engage patient in decision making

Creating ombudsman programs as means to approach patients and provide them with the correct legal measures whenever and error or adverse event occurs, was a new concept to many participants. This approach however, was thought to be difficult to implement at the time being.

Next Steps

Recommendations and Next Steps

Participants discussed and agreed on the following recommendations and next steps:

Recommendations

Recommended action	Stakeholders involved
Develop a national council on clinical governance Then national council can be commissioned by key organizations (such as the World Health Organization) to fulfil its duties The council can include four committees each responsible of the following clinical governance constituents: the development and implementation of evidence-based guidelines, education and training of healthcare providers, audit and feedback and performance appraisal	⇢ MoPH ⇢ World Health Organization ⇢ Syndicate of Private Hospitals ⇢ Order of Physicians ⇢ Order of Pharmacists ⇢ Order of Nurses ⇢ Other third party payers (public and private)
Develop context specific evidence-based clinical guidelines. An alternative is to adapt international guidelines to the Lebanese context Establish a national guideline committee to develop, support, and oversee a common, reliable, and transparent process for guideline development and adaptation. The committee would collaborate with academic institutions and stakeholders such as medical professional societies	⇢ MoPH ⇢ Academic institutions ⇢ Syndicate of Private Hospitals ⇢ Order of Physicians ⇢ Order of Pharmacists ⇢ Order of Nurses
Integrate patient safety and quality improvement education into healthcare students and trainees' curricula The curricula can include quality improvement tools, methods and interventions via small tests of change	⇢ MoPH ⇢ Ministry of Education and Higher Education ⇢ World Health Organization ⇢ Syndicate of Private Hospitals ⇢ Order of Physicians ⇢ Order of Pharmacists ⇢ Order of Nurses ⇢ Universities and technical schools

Recommended action	Stakeholders involved
	⇢ Healthcare organizations
Develop a Lebanese Board and re-evaluate the colloquium examinations of providers This can be achieved by lobbying and advocating for the draft laws that were submitted by the Order of Physicians to the parliament and are still not executed	⇢ MoPH ⇢ Ministry of Education and Higher Education ⇢ Syndicate of Private Hospitals ⇢ Order of Physicians ⇢ Order of Pharmacists ⇢ Order of Nurses
Provide Continuing Medical Education and make it mandatory to all providers This can be achieved by lobbying and advocating for the draft law that was submitted by the Order of Physicians to the parliament and is still not executed	⇢ MoPH ⇢ Syndicate of Private Hospitals ⇢ Order of Physicians ⇢ Order of Pharmacists ⇢ Order of Nurses ⇢ Healthcare organizations
Conduct internal audit and feedback on organizations' and providers' performances	⇢ MoPH ⇢ Healthcare organizations management ⇢ Syndicate of Private Hospitals ⇢ Mortality and morbidity committees from healthcare organizations
Conduct physicians' performance appraisal in healthcare organizations Use the Multisource Feedback as a tool for performance appraisal, make sure the tool is context specific, and monitor and evaluate its implementation	⇢ MoPH ⇢ Order of Physicians ⇢ Syndicate of Hospitals ⇢ Healthcare Management ⇢ Selected providers
Revise the current accreditation system, mandate patient safety indicators, and create a system of incentives that links to contractual agreement, regulations, accreditation status, and performance indicators The revision of the accreditation system and contractual agreement could encompass: ⇢ Developing a new governance model for the	⇢ MoPH ⇢ Academicians ⇢ Syndicate of Private Hospitals ⇢ Third party payers (public and private) ⇢ Order of Physicians ⇢ Order of Pharmacists

Recommended action	Stakeholders involved
accreditation program which includes renewal of accreditation status on a regular basis; certification and re-certification of national auditors; and the presence of mechanisms to ensure quality is sustained post-accreditation	⇢ Order of Nurses
⇢ Ensuring patient safety goals, indicators and training requirement are explicit in the accreditation standards of hospital and primary healthcare accreditation programs	
⇢ Ensure continuous training of healthcare providers and organizations on patient safety practices	
⇢ Scaling up accreditation to cover all providers of care in the country (primary care, long term care, mental health, clinics, polyclinics, diagnostic facilities and laboratories)	
⇢ Encouraging public and private third party payers to link incentives and contractual agreements to accreditation status or attainment of specific quality and patient safety indicators	
⇢ Improving the new re-imbursement formula for hospitals by including measures and outcomes indicators that reflect hospital's actual performance measures	
⇢ Designing and implementing a financial arrangement for PHC (i.e. performance contracting system) that includes centers that pass accreditation	
⇢ Implementing re-certification and re-licensing of healthcare providers on a regular basis	
⇢ Establishing a national set of standardized, valid and applicable performance indicators for mandatory reporting that is specific for hospitals and primary healthcare and link to incentives. Publication of results could be utilized at a later stage, once the system's capacity is built with respect to valid and reliable reporting and a culture of trust is fostered among stakeholders	

Recommended action	Stakeholders involved
Develop a pre-hospital care program This program can be reinforced by adding a standard into the accreditation system that supports the provision of basic life support and trauma trainings to all providers	⇢ MoPH ⇢ Red Cross and other organizations that provide ambulatory services (Red Crescent, Civil Defence) ⇢ Syndicate of Private Hospitals ⇢ Order of Physicians ⇢ Order of Nurses ⇢ Healthcare organizations management
Develop incident reporting systems Reporting systems can be developed through a two-stage approach: ⇢ The first stage is within the first 3 years, involves implementing the system at the organizational level ⇢ The second stage, is within the following 3 to 5 years, and involves integrating the system at the national level, with the MoPH being in charge of its implementation The following can facilitate reporting: ⇢ Integrate within the MoPH website a section that shares organizations success stories. This section will be a portal for the various organizations to learn and improve ⇢ Make reporting on a national level voluntary, anonymous and non-punitive, so that providers feel more comfortable when reporting incidents ⇢ Develop a system at the various professional orders that allows assessment of reported incidents, to be able to identify which should be sent for further investigation, since not all incidents reported are not due to preventable medical errors Incentives for healthcare professionals to report on incidents include: ⇢ Simplifying incident report forms so that they are	⇢ MoPH ⇢ Healthcare organizations ⇢ Healthcare providers ⇢ Syndicate of Private Hospitals ⇢ Order of Physicians ⇢ Order of Nurses ⇢ Order of Pharmacists

Recommended action	Stakeholders involved
easily and rapidly filled ⇢ Providing feedback so that those reporting know that reporting is coming into an effect ⇢ Promoting a non-punitive environment ⇢ Ensuring protection for the healthcare professional by providing immunity from legal action	
Conduct patient safety campaigns, and develop patient safety education material, such as brochures and flyers, to enable patient empowerment Educate patient families to engage them in shared decision-making and improve quality of care	⇢ MoPH ⇢ Lebanese Society for Quality and Safety in Healthcare and other NGOs ⇢ Healthcare organizations ⇢ Healthcare providers ⇢ Academicians and researchers ⇢ Order of Physicians ⇢ Order of Nurses ⇢ Order of Pharmacists ⇢ Syndicate of Private Hospitals
Conduct capacity building workshops for media on how and when to report on (potential) medical errors and other medical incidents Conduct awareness campaigns to media so that they report on medical errors in an informed manner This will allow scientific reporting of medical errors by media, and will limit media jumping into conclusions before investigations are done and verdicts are out	⇢ MoPH ⇢ Ministry of Information ⇢ Press syndicate ⇢ Academicians

Next Steps

It was agreed that the K2P dialogue summary report along with the revised K2P Policy Brief will be used by each stakeholder organization as guiding policy document and that they will communicate internally and externally with relevant bodies, agencies and department, in order to push agendas and advocate for improvements. Also, the need to operationalize key recommendations and put them into action was discussed in the dialogue.

Knowledge to Policy Center draws on an unparalleled breadth of synthesized evidence and context-specific knowledge to impact policy agendas and action. K2P does not restrict itself to research evidence but draws on and integrates multiple types and levels of knowledge to inform policy including grey literature, opinions and expertise of stakeholders.

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