

The Patient Safety Movement Foundation

2023 Annual Report



**PATIENT
SAFETY
MOVEMENT**

First, Do No Harm. ZERO by 2030

LETTER FROM OUR CEO



Dear Friends,

This has been an integral year for both the Patient Safety Movement Foundation and patient safety. The collaborations that are advancing our work are very exciting, and there is no doubt in my mind that once we have all hands on deck, we can create a global system that eliminates preventable medical harm.

Under the direction of Dr. Durkin, myself, and Dr. Sanaz Massoumi, we launched a new website, restructured our commitment model, focused on our four organizational aims, created the Patient Safety Leadership Association, and launched Project ZERO. We shared more than a dozen patient stories in critical areas, like sepsis, and continued our work to streamline the Actionable Evidence-Based Practices so they are even easier to implement.

Our 10th anniversary Summit was the first in-person gathering since Covid, and it was powerful – bringing together patient safety experts, patient advocates, and leaders from around the world. Our Founder, Joe Kiani, co-led a PCAST working group on patient safety with Microsoft's Chief Scientific Officer, Eric Horvitz. They released its findings and recommendations on patient safety in a report to US President Joe Biden. Titled "A Transformational Effort on Patient Safety," the report also outlines the many ways that "patient safety is an urgent national public health issue."

This year, we worked closely with our esteemed board members to prioritize the most impactful projects, and we were able to reduce costs system wide. We created the Patient Safety Alliance and are collaborating closely with key national and global patient safety organizations, like the World Health Organization.

We couldn't have accomplished all that we did without the help of our patient safety volunteers and our corporate sponsors. We can't wait to show you what we have planned for 2024!

With you in health,

A handwritten signature in dark ink, appearing to read "Michael Ramsay", followed by a small "MD" or similar initials.

Michael Ramsay
Chief Executive Officer, PSMF



Our **vision**
is for a safer healthcare
system, with **ZERO**
preventable patient **harm**.



We need our movement in patient safety to be a global family. Wherever we have come from, we have raised the flag of awareness that we need to **reduce deaths and harm** from avoidable errors in healthcare everywhere we go. But why have we consistently failed in making headway? Because we haven't worked together across the globe. We have been siloed in our systems as well as in our campaigns. We have been trying to promote one model—usually our personal or organizational model or solution—rather than working together to change the response. We need a collective movement to reduce harm, and we need **a multidimensional approach** to ensure all parties can work together despite the difficulties.

– Mike Durkin, Chair, PSMF

Our **mission**
is to disseminate **Actionable Evidence-Based Practices**,
advance their integration by
healthcare organizations, and
cultivate data transparency
by 2030.

Strategies to ZERO

The Patient Safety Movement Foundation’s vision is to bring about safer healthcare systems around the world, with ZERO preventable patient harm. Our strategy is centered on four foundation goals:



Since our inception more than a decade ago, our primary means for eliminating preventable patient harm has been through the development and dissemination of Actionable Evidence-Based Practices. We engage multidisciplinary teams of experts that target the leading causes of death and harm in clinical settings to formulate and review these step-by-step guidelines. More than 40 of these blueprints covering a wide range of medical conditions, procedures, and healthcare environments are available free on our website, and we are continually in the process of updating them.

The quickest way to inform and motivate improvements in the healthcare system is to know the actual number and types of preventable medical errors occurring. Sharing data about patient harm events and the outcomes of new safety measures is an essential aspect of the Patient Safety Movement Foundation’s advocacy work. We work with healthcare institutions across the globe to help them understand what is at stake and steps they can take right now to protect patients by sharing data.

A necessary component of achieving our goal of ZERO patient harm and mortality is changing the way healthcare providers are financially incentivized. Our current fee-for-service healthcare payment environment does not encourage value-based treatments. Our aim is to remove this misalignment so that providers no longer have to depend on volumes and can focus on delivering high-quality service across the continuum of care.

We are two million times safer sitting on an airplane than lying in a hospital bed. That’s because two federal agencies, the National Transportation Safety Board and the Commercial Aviation Safety Team, have for decades researched the causes of airline disasters and developed systems, technologies, and practices to prevent them from happening again. A similar agency focused on patient safety, which we are working to help make a reality, would save untold lives.



Martha Mills

Merope Mills’s 13-year-old daughter, Martha, had a seemingly minor bicycle accident. What doctors first believed was internal bruising turned out to be pancreatic trauma. A few weeks into her hospital stay, Martha developed a fever and started to bleed from both the line in her arm and the tube from her abdomen. Clear signs of sepsis were missed, and a vibrant child died from an easily treatable injury.

President's Council of Advisors on Science and Technology Report: "A Transformational Effort on Patient Safety"

In early September, after months of research and preparation, the President's Council of Advisors on Science and Technology (PCAST) released its findings and recommendations on patient safety in a report to US President Joe Biden, a long-time champion of patient safety. Titled "A Transformational Effort on Patient Safety," the report drew much-needed attention to the urgency and scope of patient safety harms as a national public health issue. PSMF Founder Joe Kiani co-led the PCAST Working Group on Patient Safety, along with Microsoft's Chief Scientific Officer, Eric Horvitz, in preparing the report.

The report points out that medical errors and patient injuries persist at alarmingly high rates despite ongoing efforts to improve quality care on the part of practitioners and their organizations. It goes on to reveal that despite the efforts of many healthcare workers and organizations to implement evidence-based safety protocols, implementation of many of these known solutions has lagged.

Noting that changes will be far more likely with strong committed government leadership, the report outlines recommendations in the following four main areas.

PCAST Recommendations

1

Establish and Maintain Federal Leadership for the Improvement of Patient Safety as a National Priority.

As outlined in the report, establishing such leadership entails appointing a patient safety coordinator who reports directly to the president on efforts to transform patient safety among the relevant federal departments. It also comprises the creation of a multidisciplinary National Patient Safety Team (NPST) that is inclusive and representative of all affected populations.

2

Ensure That Patients Receive Evidence-Based Practices for Preventing Harm and Addressing Risks.

The second recommendation is broad in scope, encompassing two key PSMF goals. The first is to identify the highest priority harms and promote patient safety by incentivizing the adoption of evidence-based solutions, which includes a system of accountability. The second seeks to advance data transparency among healthcare organizations in a way that assures access to the tracking of harms. An essential aspect of both these goals is improving the safety of healthcare workers along with their patients.

3

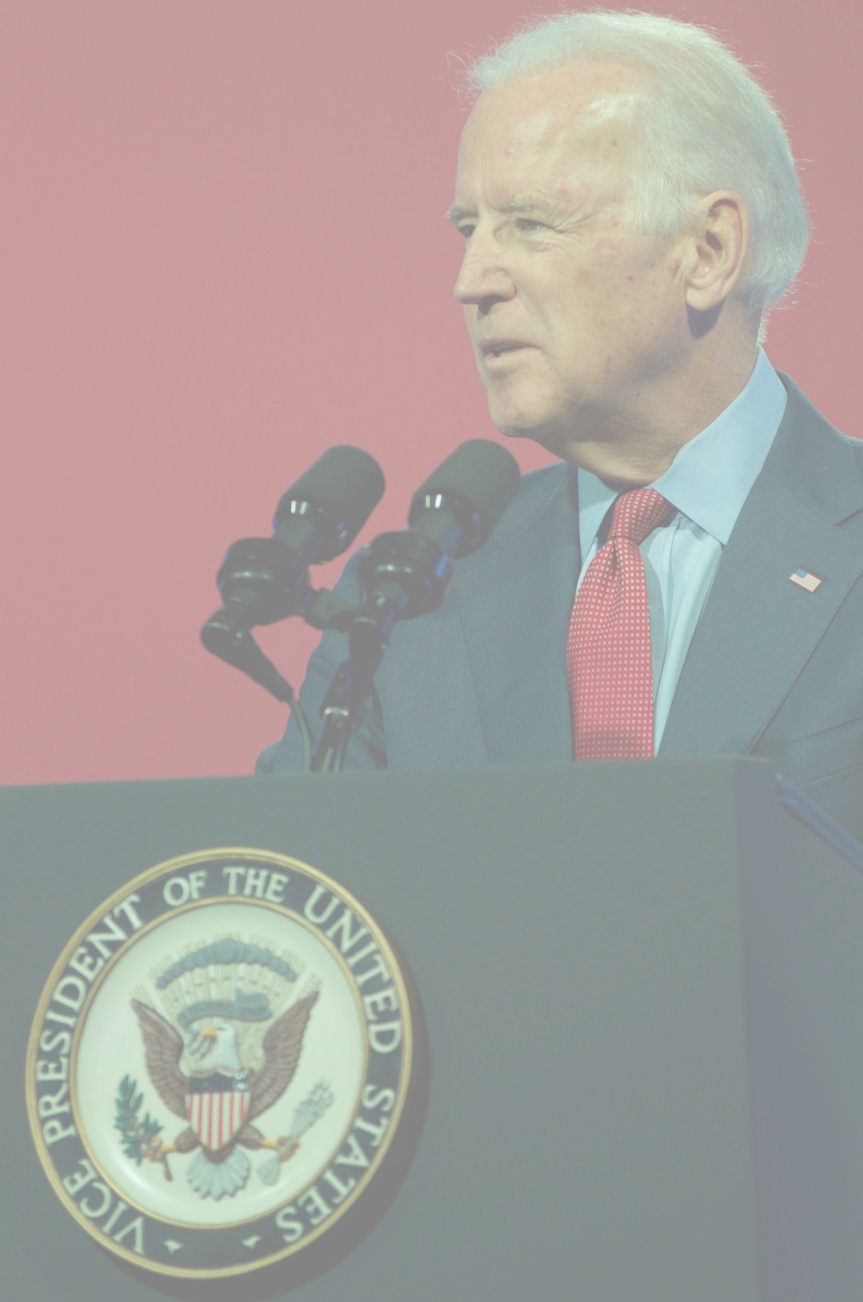
Partner with Patients and Reduce Disparities in Medical Errors and Adverse Outcomes.

This recommendation addresses long-standing gaps in racial, ethnic, and socioeconomic disparities in healthcare whereby marginalized groups tend to experience preventable medical harms at disproportionate rates. It proposes the implementation of a "Whole of Society Approach" to engage all patients in the effort to improve patient safety and to reduce these disparities by improving data transparency.

4

Accelerate Research and Deployment of Practices, Technologies, and Exemplar Systems of Safe Care.

The last recommendation focuses on important hows, including the development of a national patient safety research agenda, a call to harness revolutionary advances in information technologies, and building out the capacity of federal healthcare delivery systems in a way that they can serve as models for patient safety improvement.



The Summit

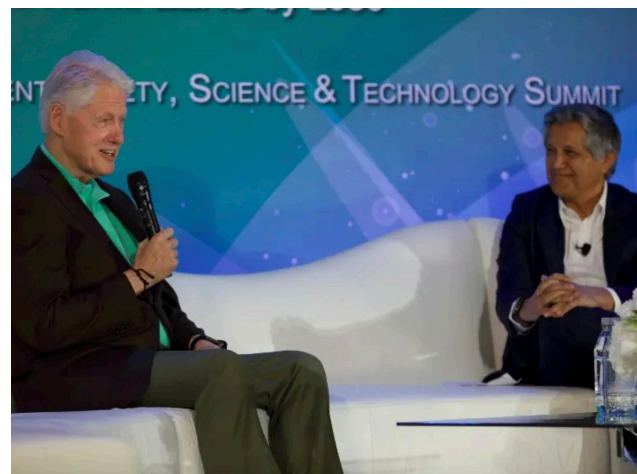
10th Annual World Patient Safety, Science & Technology Summit

Our 10th Annual World Patient Safety, Science & Technology Summit marked the return of our in-person gathering of patient safety experts, leaders, and advocates from around the world.

And what a gathering it was!

With the pandemic years bringing to light the myriad ongoing gaps in patient safety, while exacerbating others, the event's sold-out crowd was eager to learn, discuss, and take action.

The 2023 Summit was defined by two major themes: a call for greater urgency in eliminating the preventable harm that remains so devastatingly prevalent within healthcare, as well as optimism that artificial intelligence and datasets will pave the way to making hospitals safer.



"People are human; there are honest mistakes that will always be made. But systematic error should have been eradicated by now, given the level of data we have."

– Bill Clinton
42nd President of the United States

"Technology is changing," said Dr. Michael Ramsay, the Patient Safety Movement Foundation's CEO, in his address to the Summit.

"We're now getting real data. We know what the outcomes are in hospitals. We're all humans, we're all a little bit competitive, and I think you react to data. This will make a difference."

The Summit's featured speakers included representatives from the World Health Organization (WHO), the Centers for Medicare & Medicaid Services (CMS), as well as members of the

President's Council of Advisors on Science and Technology (PCAST).

During an on-stage conversation with PSMF Founder Joe Kiani, former US President Bill Clinton discussed the challenges of persuading more hospitals to commit to making patient safety a priority: "We've got to develop a culture of conversion." Adding, we have to figure out "how to make people feel that they're not going to be shamed if they admit that they have been doing something that doesn't work." Referring to the wealth of data on the causes of preventable patient harm and the proven solutions, Clinton noted that systematic medical errors in hospitals should have been eradicated by now, calling the primary impediment to progress "institutional resistance."

In a keynote address, Don Berwick, a former CMS administrator, outlined a list of measures to center patient safety in the strategic vision of every healthcare system leader. He recommended steps ranging from a government-wide Patient Safety Coordinating Group to an incentive-driven system implemented by CMS and private sector organizations to encourage hospitals to adopt patient safety-led priorities and practices and report their progress openly and publicly. He urged healthcare to follow the example of the aviation industry: "You're two million times safer in an airplane seat than a hospital bed."

The Summit also heard from family members representing patients who had experienced harm as well as from a dedicated Patient and Family Engagement panel, discussing the importance of involving patients more in their care. On the panel was Merope Mills, who suffered an appalling tragedy when her 13-year-old daughter, Martha, died as a consequence of a catastrophic chain of medical errors. Since Martha's death, Mills has become a patient safety campaigner, calling for a measure known as "Martha's Rule," which would allow patients and their families to request a second medical opinion in all English hospitals. She told the Summit, "I'd like there to be more power in the hands of the patients.... The main thing that I felt when I was in hospital was totally powerless."

Visit the Events section on our website, psmf.org, to access complete videos of every Summit speech, panel, and presentation.



Project ZERO

Project ZERO represents our collective efforts with healthcare organizations around the world to implement evidence-based practices. In addition to providing best-practice blueprints, we empower healthcare organizations with implementation science, encouraging clinicians to adopt the necessary steps to foster safety. This initiative is designed to reinforce our mission to spread standardized practices that can be integrated within healthcare systems worldwide. We engage patients, families, and patient groups, representing those who have been harmed so that healthcare systems are improved based on the needs of patients and their families at every stage.



“There are hospitals in this nation that have driven certain kinds of infections to zero for months at a time. There are hospitals that have virtually eliminated pneumonias that can come from ventilator machines, or painful pressure sores from prolonged time in bed. They have not done this by blaming their workers or yelling at their doctors, but rather by adopting safe practices that protect both the workers and the patients from hazards.”

– Don Berwick, MD, MPP, FRCP
Former Administrator of the Centers for Medicare and Medicaid Services



Sha-Asia Semple

When 26-year-old Sha-Asia Semple went into labor, a catheter to deliver the anesthesia should have gone about four inches into her lower back, but the anesthesiologist kept inserting the line, threading it in and up more than 13 inches. He then administered a full dose of anesthesia without waiting to see how she responded to the small test. Her breathing grew labored and then stopped. Her baby, Khloe, survived and Sha-Asia did not. Khloe will never know her mom, and Sha-Asia’s mother, Rayshema, lost her best friend.

Patient Safety Awareness

Patient Safety Awareness Week: March 12-18, 2023

Patient Safety Awareness Week promotes education and advocacy of critical issues impacting healthcare safety. Started in 2002 by the National Patient Safety Foundation, the annual event was conceived to stimulate discussions on how patient safety can be improved in healthcare systems.

Patient Safety Awareness Week acknowledges that patient safety is the collective responsibility of healthcare systems, healthcare workers, and patients. The week highlights the role that both medical staff and patients can play to assure overall safety, providing the public with educational resources that better equip them to make informed healthcare decisions.

This year, the Patient Safety Movement Foundation participated in Patient Safety Awareness Week with a social media campaign. Each day's post focused on one of the most common sources of preventable medical harm in hospitals.

“In the vast majority of cases of harm, somebody knows that something’s wrong, but they weren’t listened to or didn’t feel comfortable speaking up.”

– Peter J. Pronovost, MD, PhD, FCCM, Chief Clinical Transformation Officer, University Hospitals (UH), Northeast Ohio



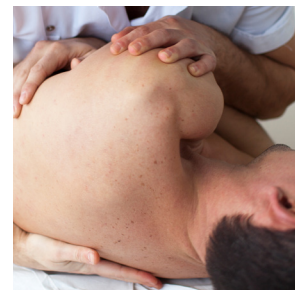
March 13: CLABSI

An estimated 41,000 patients in US hospitals are harmed each year by central line-associated bloodstream infections (CLABSI). Evidence-based protocols can reduce CLABSIs by up to 80%.



March 14: CAUTI

Roughly 10,000 people die in US hospitals each year from a catheter-associated urinary tract infection (CAUTI). Most of these infections are preventable.



March 15: Pressure Ulcers

Pressure ulcers impact up to 70% of older hospitalized adults. They can cause pain, infection, and prolonged hospital stays. Do you know all the warning signs?



March 16: Falls

Nearly 1 million patient falls occur in US hospitals every year, costing tens of billions of dollars and unnecessary harm and suffering.



March 18: Medication Errors

Medication errors and adverse drug reactions occur in half of all surgeries – a leading source of preventable medical error resulting in patient harm. During Patient Safety Awareness Week, learn proven protocols to protect patients.

World Patient Safety Day 2023



Engaging Patients Is Paramount

The Patient Safety Movement Foundation leadership took an active role in this year's World Patient Safety Day activities on September 17. This year's theme, "Engaging Patients for Patient Safety," particularly aligned with the PSMF's fundamental approach to engage patients and their families in all our efforts. Evidence shows that when patients are treated as partners in their care, significant gains are made in safety, patient satisfaction, and health outcomes.

WHO established World Patient Safety Day in 2019 as a global public health day with the adoption of resolution WHA72.6 ("Global action on patient safety"). Its objectives are to increase public awareness and engagement, enhance

global understanding, and work toward global solidarity and action by member states to enhance patient safety and reduce patient harm.

Through this year's World Patient Safety Day slogan, "Elevate the voice of patients!" WHO called on all stakeholders to take necessary action to ensure patients are involved in policy formulation, represented in governance structures, engaged in codesigning safety strategies, and active partners in their own care—something the Patient Safety Movement Foundation has been doing since its inception.

To help advance patient safety awareness on this important day, PSMF CEO Dr. Michael Ramsay participated in a March to the Capitol in Washington, DC. He also spoke at a virtual seminar organized by Imperial College London and Imperial College Healthcare NHS Trust, on September 14. PSMF COO Dr. Sanaz Massoumi

meanwhile was a featured speaker at WHO's World Patient Safety Day Global Conference on September 12–13, presenting on the topic "Empowering Patient Stories for Safer Healthcare."

To further examine the central themes of this year's World Patient Safety Day, we also hosted a webinar titled "The Critical Role of Healthcare Professionals in Engaging Patients and Elevating Their Voice." The virtual presentation included Dr. Steve Barker, Heather Gocke, and Robert Imhoff, in conversation with Dr. Massoumi. Another webinar we presented for World Patient Safety Day, "Engaging Patients for Patient Safety and Elevating the Voice of Patients," brought together the expertise of Helen Haskell, Dr. Neelam Dhingra, Dr. Angela Coulter, Dr. Maren Batalden, and Sue Robins. Both webinars are viewable on our website and YouTube channel.



"Families are clearly positioned as partners or potential partners in care. They can ensure safe care, and they can try to ensure ethical decisions...They play a key role in providing continuity of care through those transitions of care and handovers, which can be high risk situations."

– Sir Liam Donaldson, Former Chief Medical Officer of the United Kingdom



Opioid Patient Monitoring

The Urgent Need for Opioid Patient Monitoring

Most people are aware of the rising opioid-related death rates: currently more than 75,000 in the US every year. What isn't as widely known: 0.5% of all hospital patients treated with opioids for acute postoperative pain develop opioid-induced respiratory depression, which carries a fatality rate of 40%. Like deaths caused by accidental overdose, these opioid-related deaths are also 100% preventable.

Two years ago, the Inpatient Opioid Safety Act was introduced in the US House of Representatives. The new law would have greatly reduced the incidence of injury and death from opioid-induced respiratory depression under the Medicare and Medicaid programs. It called for continuous monitoring of blood oxygen levels for any inpatient administered with opioids, with an alarm alerting healthcare team members

if the patient's levels dropped below a certain threshold. Unfortunately, the bill didn't get a vote and has since been tabled indefinitely.

Anesthesiologists and opioid experts across the country continue to sound the alarm on the urgent need for policymakers to do more to protect patients. Last June, at our annual World Patient Safety, Science & Technology Summit, Frank J. Overdyk, an adjunct professor of anesthesiology, raised an important question, "Why don't we have a safety culture around opioids like we have around deep vein thrombosis, like we have around bedsores, like we have around falls?"

Overdyk and other experts say new opioid safety policies are needed in four main areas to prevent catastrophic outcomes.

For example in autopsy reports, the cause of death may be marked as fatal arrhythmia or cardiac ischemia even though opioid-induced respiratory depression led to it.

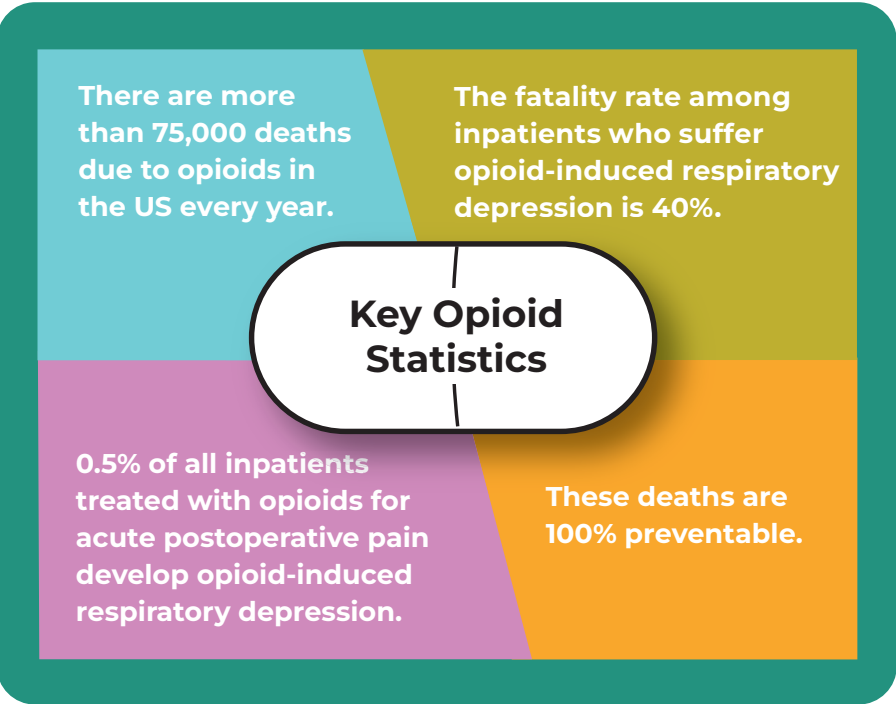
Continuous Monitoring

Compelling evidence demonstrates that using continuous monitoring devices, such as pulse oximeters to assess the vital signs of patients prescribed opioids, can help save lives. George Blike, professor of anesthesiology at Dartmouth College, said that after deploying a pulse oximetry-based system at Dartmouth Medical Center in the mid-2000s, deaths from opioid-induced respiratory depression dropped to zero over a 10-year period.

Automatic Alarms Through Artificial Intelligence

Continuous monitoring can be combined with artificial intelligence to enable remote monitoring of patients after they are discharged and sent home with opioids. Daniel Cole, professor of clinical anesthesiology at UCLA, envisions a future in which "patients are supported by artificial intelligence. They go home with wearables, and all that data is fed into a central repository."

For any real change, regulatory pressure is needed, according to Blike. "I think it needs to be a standard of care whether it's through CMS or other means. Maybe that's a heavy hammer, but I think it just needs to be a standard."



Education

Despite the prevalence of deaths from opioid-induced respiratory depression, there is an education gap within US hospitals when it comes to the dangers of opioids. From surgeons to nurses, a large percentage of medical professionals are still relatively unaware of the risks the drugs pose.

Metrics

One of the reasons opioid-induced respiratory depression still slips under the radar as a major patient safety problem within healthcare is because fatalities are often not marked as being opioid related.



Anders Pederson

Kelly Pederson was fortunate to have a close sibling, Anders, immediately volunteer one of his kidneys when she experienced kidney failure. At 28, he was healthy and a match. The transplant went perfectly well. Less than 24 hours later, Anders went into cardiac arrest, was revived, but was pulled off life support nine days later, brain dead. Anders died of an opioid overdose because a nurse practitioner gravely miscalculated the dose of opioids Anders received from a patient-controlled dispensing device. If Anders was being monitored with a pulse oximeter, an alarm would've sounded once his blood oxygen had fallen too dangerously low.

Policy Advocacy

The Value-Based Patient Safety Model Act

Behind-the-scenes, the Patient Safety Movement Foundation continues its advocacy work year-round to engage policymakers, government agencies, and elected officials in advancing new programs and policies at the federal and state level that will have the greatest impact on saving patient lives.

One major point of emphasis this year was a recommendation to the Centers for Medicare and Medicaid Services (CMS) to test the effect of an aligned incentives patient safety care management model. Tentatively titled the “Value-Based Patient Safety Model Act,” the proposal would require the Secretary of Health and Human Services through the Center for Medicare & Medicaid Innovation (CMMI) to develop and implement a model to demonstrate the impact of aligning Medicare payment incentives and penalties to patient safety. Specifically, the new CMMI model would align Hospital Value-Based Purchasing (VBP) Program incentives and penalties with medical facility implementation of the best practices to eliminate preventable medical errors. It would do so in part by increasing the current 2% reimbursement penalty to 10%, while increasing the reimbursement incentive by including the adoption of best practices as an equal component of the safety category. If implemented, the new policy would dramatically reform our healthcare system’s approach to quality with deference to the patient’s needs and the provider’s expertise, as well as save lives and taxpayer dollars.

“I think our next mission as a grassroots movement is to call the people in office and demand for local states, governments to hardwire patient safety, aligned incentives, so that every hospital puts the evidence-based practices in place.”

– Joe Kiani, PSMF Founder



Andrew Sheldrick

Melissa’s son Andrew had a sleep disorder called parasomnia. The doctor prescribed tryptophan, and Andrew’s night waking stopped and his behavior improved. The following year, Melissa started receiving the prescription in liquid form from a nearby compound-ing pharmacy. After 18 months without any problem, Andrew did not wake up one morning. Four months later, Melissa received a call from the police homicide division. The medication they had received contained no tryptophan at all but rather baclofen mixed in the same concentration – three times the lethal dose for an adult. The pharmacy had made a medication error, and the family will never be whole again.

Patient Safety Fellows

Patient Safety Fellows Make an Impact

Our Global Interprofessional Patient Safety Fellowship launched in August 2021 to provide a unique opportunity for healthcare professionals around the world to expand their knowledge in the theory and practice of patient safety. The program combines a year-long curriculum developed by patient safety experts in a variety of areas, taught via monthly live virtual classroom sessions, with a hands-on improvement project that explores and advances issues of patient safety in each fellow's respective professional environment.

We recently followed up with each of the four fellows from the program's inaugural cohort to learn how the fellowship program has helped them make an impact in their efforts to improve patient safety in their home countries.



Dr. Ebikapaye Okoyen

Dr. Ebikapaye Okoyen, who works for the Ministry of Health in Yenagoa, Nigeria, as a program manager focusing on quality of care and patient safety, was proud to share that for the first time in the history of the health ministry, World Patient Safety Day was observed. The observance included a rally in Yenagoa, as well as radio and TV appearances to help raise awareness. He has also been making progress in advocating for and training frontline healthcare workers in patient safety across five hospitals, another first for most of the trainees.



Dr. Elizabeth Namugaya Igaga

Also based in Africa, Dr. Elizabeth Namugaya Igaga was able to apply the knowledge she gained through the fellowship to advance in her career. An anesthesiologist and critical care intensivist from Kampala, Uganda, Dr. Igaga, midway through the year-long fellowship program, was hired as the Director of Safety and Quality for Medical Programs for Smile Train, the international nonprofit that provides cleft surgeries. For her, it was a perfect opportunity to find work with an organization whose mission to help others and passion for quality of care aligned with her own.



Dr. Luis Torres Torija Arguelles

Dr. Luis Torres Torija Arguelles continues his close connection with the Patient Safety Movement Foundation post-fellowship by serving as our ambassador in Mexico, where he is a physician and quality of clinical care specialist. He credits the fellowship for the skills he learned to work collaboratively and to account for contextual factors. This is especially relevant in his efforts to understand the complex factors involved in creating a culture of safety, especially where the concept of patient safety is new to many.



Samar Khaled Hassan

Working as a senior accreditation officer for the Health Care Accreditation Council in Jordan, Samar Khaled Hassan focused on the issue of antimicrobial resistance for her fellowship project. The knowledge she gained as a PSMF fellow has helped further her efforts to engage health professionals and policymakers to identify areas for improvement and address potential barriers to implement changes across a variety of health providers in her country.

We could not be more pleased to have such a distinguished group of fellows actively spreading their knowledge to bring about lasting improvements in patient safety on three different continents.

Class of 2023

Like our 2021–2022 fellows, our current cohort represents a broad diversity of cultural and professional backgrounds. Also like the previous group, what unites them is their passion for learning everything they can to improve patient safety.

Manal Younus, PhD, is the founder and director of the Iraqi Pharmacovigilance Center. With more than 20 years of experience in medicine regulation, pharmacovigilance, and clinical pharmacy, she has served on many regional and international committees.

Melanie Whitfield is the Associate Director of Patient Safety, Clinical Governance and Risk Management and a Trust Patient Safety Specialist at an NHS Trust in London. Also a registered midwife, she has 25 years of clinical experience and holds a masters in patient safety.

Dr. Frank Gitonga is an anesthesiologist at the Isiolo Regional Military Hospital in Kenya. He has completed a European Society of Intensive Care Medicine fellowship in acute kidney injury as well as training in echocardiography and hemodynamic monitoring.

Natalia Camargo is a registered nurse and healthcare quality management specialist in São Paulo, Brazil. With nine years of experience working in many different hospital environments, she was responsible for the Patient Safety Center of São Paulo's Public Healthcare Unit.

2023 Speaking Engagements



As awareness of the urgent crisis around preventable patient harm grows, the Patient Safety Movement Foundation leadership team and governance board members are increasingly called upon for their expertise to speak at healthcare-related events all over the world, both virtually and in person.

Kicking off this year's speaking engagements, PSMF Founder Joe Kiani gave an in-person keynote at the World Patients Alliance's 5th Global Ministerial Summit on Patient Safety, which took place in Montreux, Switzerland, on February 23-24.

In May, PSMF CEO Dr. Michael Ramsay spoke at the 2023 International Congress of ILTS, ELITA and LICAGE, held in Rotterdam, Netherlands. And then in July, both he and PSMF COO Sanaz Massoumi spoke at the 2nd Conference on the Atlantic Coast of the Collaborative Latin American Forum on Health Quality and Safety.

As part of World Patient Safety Day activities on September 14, Dr. Ramsay presented at a seminar organized by Imperial College London and Imperial College Healthcare NHS Trust. Titled "Elevating Patient Voices: Celebrating World Patient Safety Day," the virtual event's purpose was to elevate patient and family voices for patient safety. That same week, on September 12-13, Dr. Massoumi participated in WHO's World Patient Safety Day Global Conference. Her presentation on "Empowering Patient Stories for Safer Healthcare" reflected WHO's theme for the 2023 World Patient Safety Day, "Engaging Patients for Patient Safety."

Also in September, Joe Kiani was invited to speak at the Clinton Global Initiative 2023 Meeting. Kiani addressed the issue of opioid overdoses on a panel about health equity hosted by Chelsea Clinton. A few days later, Kiani also spoke at the BETA Annual Member Symposium. That same week, Dr. Ramsay and Dr. Massoumi teamed up again at SAFETY4ME's 3rd International Week of Patient Safety, held September 18-21.

The Patient Safety Movement Foundation's Chair, Mike Durkin, joined Dr. Ramsay and Joe

Kiani to speak at the Mexican Academy of Surgery Academic Conference on September 21-23, hosted by the Faculty of Medicine of the Autonomous University of San Luis Potosí. At the same conference, PSMF Governance Board Member Javier T. Davila moderated the panel "Transcongressional Course – Safety of the

Surgical Patient," which included Dr. Guadalupe Mercedes Lucía Guerrero Avendaño, who represents Hospital General de México "Dr. Eduardo Liceaga," our newest committed hospital.

More recently, on November 7, Dr. Ramsay presented virtually at the 22nd Annual Meeting of the International Society of Pharmacovigilance. He participated in the plenary session titled "Patient Engagement in Pharmacovigilance," speaking on "Patient Involvement in Patient Safety Across the World."

"We are going to become either a victim of medical errors or a recipient of great healthcare. We must make sure it's the latter."

– Joe Kiani, PSMF Founder

Why They Give

Our work to achieve ZERO preventable patient harm on a global scale would not be possible without the thousands of volunteers, healthcare partners, and supporters who share our vision and mission. As a 501(c)3 nonprofit, the Patient Safety Movement Foundation relies on donor support, with 91% of every dollar going directly toward our programs and core mission. Our donors come from a wide range of backgrounds and experiences. The reasons to give are many. Those who make giving to PSMF a priority have our deepest gratitude.

“Patient safety affects every single one of us, the public as much as the care providers. And already many many thousands of lives have been saved, so we know our investment is worth it.”

– Stacy Orsat, President EMEA, Masimo, Switzerland

“There are too many instances where things have gone wrong—with devastating results. I hear these stories all too often and know all too well the crushing effects of medical harm. No one should have to endure the loss of a loved one or a catastrophic condition due to a preventable situation.”

– Robert H. Imhoff III, President, Hospital Quality Institute/A division of the California Hospital Association

“I strongly support the PSMF because they work hard to build a global community to achieve Zero Harm and make the healthcare industry highly reliable.”

– Salvador Gullo Neto, MD, PhD, Founder and CEO of SAFETY4ME

“The Patient Safety Movement Foundation brings transparency to healthcare, not just the numbers but the human impact—through their focus on stories, the things that have gone wrong...If you can play a part in making their efforts accessible to every single person who does the work, closing the gaps will go a lot faster.”

– Shana Padgett, VP of Advisory Services, Value Capture LLC

“Having applied the Actionable Evidence-Based Practices, we have seen a measurable improvement in patient safety. I learn from PSMF on a regular basis.”

– Edward Loftin, Senior VP of Integrated and Acute Care/Chief Nursing Officer, Parish Medical Center

“The value of PSMF is that it promotes creativity, innovation, and iterative tests of change to advance and enhance care globally as we, collectively, pursue a shared mission.”

– Heather Gocke, M.S., RN, VP of Risk Management and Safety, BETA Healthcare Group

“I donate to the Patient Safety Movement Foundation because I believe they have the experience and global reach needed to create a safer healthcare system with ZERO preventable harm.”

– Irene Mulonni, Founder, Mulonni.com



91% of your donations go directly to our programs and core mission. Together, we can make zero patient harm a reality.

LETTER FROM THE FOUNDER



Dear Friends,

As we prepare for 2024, I am encouraged by developments this past year on a number of fronts, including our PCAST patient safety report to President Joe Biden. We laid out the problem as well as the achievable solutions, enabling top government officials to play a larger and more direct role in protecting patients.

I was re-energized seeing clinicians and patient advocates from around the world at our Summit share how committed they were to ZERO preventable harm and what they are doing to make a difference. There was a lot of exciting discussion on the potential of AI and new technological advancements in helping patient safety efforts, and we need all the help we can get on this vital journey.

I love how closely we work with other patient safety organizations around the world and how engaged we are with more patients and their families. From day one, our goal was to break the silos and bring everyone together toward a solution. Together, we are stronger and can reach our goal faster.

I believe we can eliminate preventable medical errors, but we all have a part to play. We cannot reach ZERO without you. The reality is that we are going to become either a victim of medical errors or a recipient of great healthcare. We must make sure it's the latter.

With love and appreciation,

Joe Kiani

Founder and Past Chair of the Patient Safety Movement Foundation
Founder, Chair, and CEO of Masimo Corporation

PSMF Leadership

Governance Board

Diverse in their professional backgrounds but united by a shared mission, our Governance Board is composed of leaders in health technology, public policy, healthcare delivery, information technology, safety innovation, and patient advocacy.



Joe Kiani, MS
Founder and Immediate Past Chairman of PSMF; Founder, Chairman & CEO of Masimo



Mike Durkin, OBE, MBBS, FRCA, FRCP, DSc
Chairman of PSMF; Senior advisor on Patient Safety Policy and Leadership, Institute of Global Health Innovation, Imperial College London



Michael A.E. Ramsay, MD, FRCA
Chief Executive Officer, PSMF



Sarah Kiani
Director, Masimo Foundation for Ethics, Innovation, and Competition



Abbasseh Towfigh, MPD
Executive Director and Secretary, Ayeneh Foundation



Jannicke Mellin-Olsen, MD, DPH
Past President, World Federation of Societies of Anesthesiologists



Nasim Afsar, MD, MBA, MHM
Senior Vice President and Chief Health Officer, Oracle Health



Philip D. Lumb, MB, BS, MD, MCCM, FCCP
Professor of Anesthesiology, Keck School of Medicine, University of Southern California



Najmedin Meshkati, MS, PhD
Professor of Civil/Environmental Engineering, University of Southern California



Steven J. Barker, PhD, MD
Chief Science Officer, Masimo Corporation; Professor Emeritus of Anesthesiology, University of Arizona Health Sciences



Robin Betts, RN, CPHQ, MBA-HA
Vice Chair, PSMF; Vice President, Safety Quality & Regulatory Services, Kaiser Foundation Hospitals and Health Plan, Kaiser Permanente Northern California



David B. Mayer, MD
Executive Director, MedStar Institute for Quality and Safety



Javier T. Davila, MD, MFS
Ambassador, PSMF in Mexico; Former Medical Director, Mexican Social Security Institute, Head of Medical Education, Research and Health Public Policy



Charlie Miceli, CPM
Treasurer, PSMF; Chief Supply Chain Officer, Network VP of University of Vermont Health Network



Vonda Vaden Bates
Patient Advocate, CEO, 10th Dot



Alicia Cole
Patient Safety Consultant



Jim Messina, BA
CEO, The Messina Group



Omar Ishrak, PhD
Executive Chairman and Chairman of the Board of Directors, Medtronic; Chairman of the Board of Directors, Intel



Edward Kelley, PhD
Chief Global Health Officer, ApiJect Systems

PSMF Leadership

Our Team

Our management and staff include individuals with expertise in clinical operation, systems engineering, finance, donor engagement, data management and analytics, strategic quality improvement, and project management.



Michael A.E. Ramsay, MD, FRCA
Chief Executive Officer



Sanaz Massoumi, MS, PhD
Chief Operating Officer



Nabil Soliman
Accounting and Finance
Manager



Consuelo Tolentino, BA
Executive Assistant



Armaan Meshkati, BS
Quality and Patient
Safety Strategist



Collin Walker, BS
Finance & Data Coordinator

Advisory Board

- | | |
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| Dan Cole | Stephanie Mercado |
| Tony Galbo | Martie Moore |
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