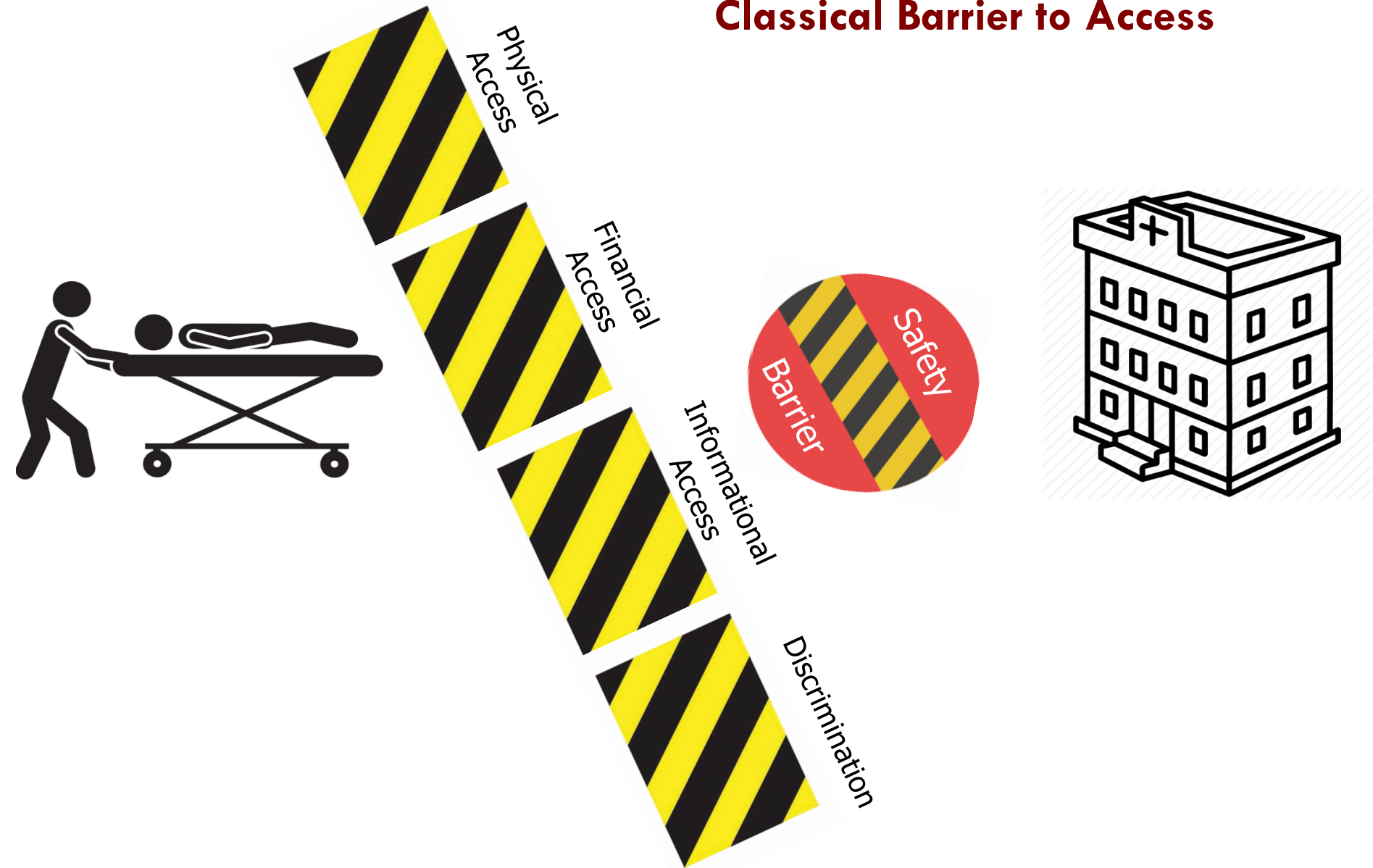World
Patient Safety
Day 17 September 2020

Implementing Patient Safety in Health Care Facilities

Nikhil Prakash
Patient Safety Consultant

Classical Barrier to Access

Physical Access

Financial Access

Informational Access

Discrimination

Barrier

Safety

Unsafe Care

Erodes the trust in healthcare system

Alters the health seeking Behaviour

Cost Trillions of dollars

Demotivate healthcare providers

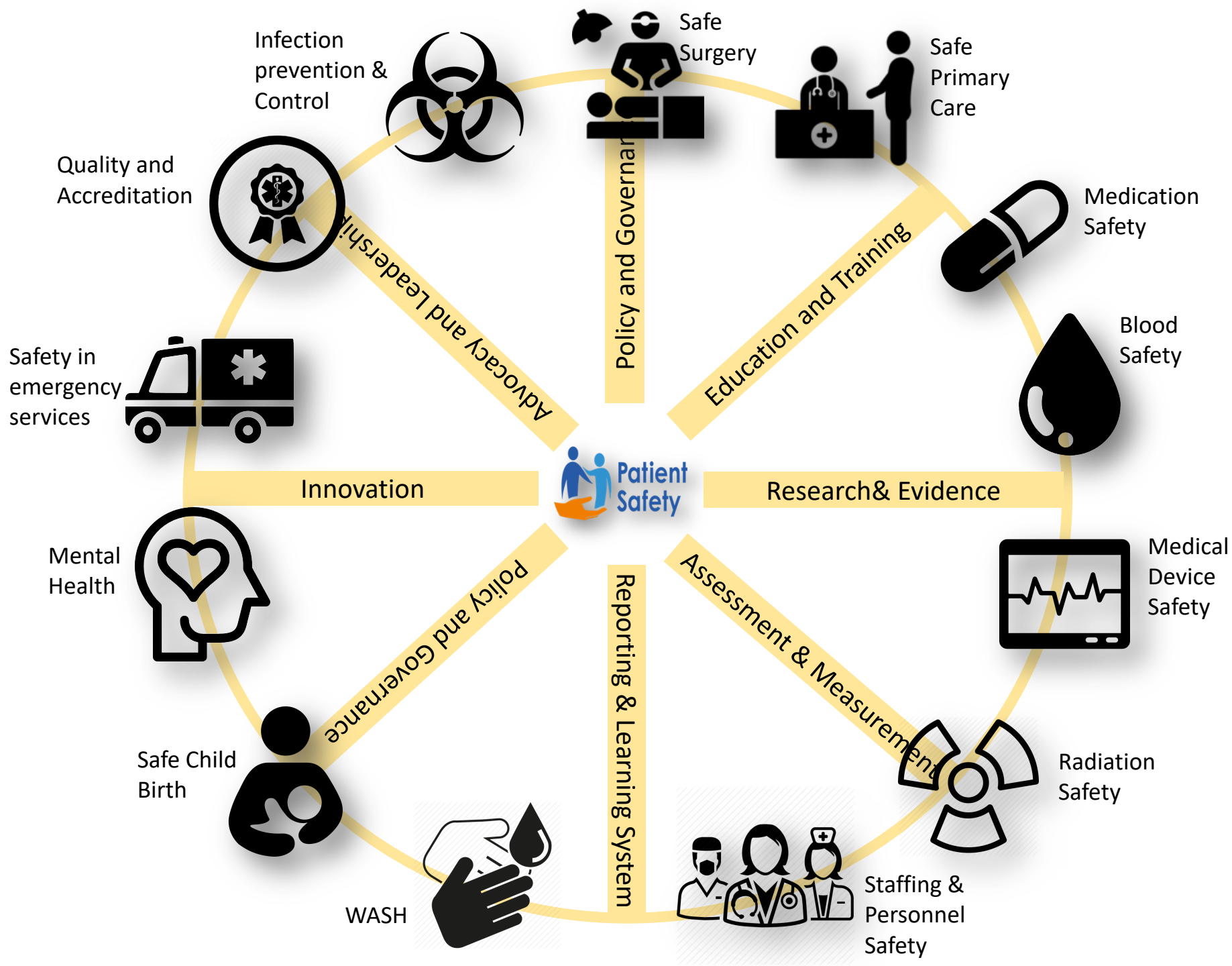Poses serious risk to the achievement of UHC

National
PATIENT SAFETY IMPLEMENTATION
Framework (2018-2025)

INDIA

MINISTRY OF HEALTH & FAMILY WELFARE
Government of India

Infection prevention & Control

Safe Surgery

Safe Primary Care

Quality and Accreditation

Medication Safety

Safety in emergency services

Blood Safety

Innovation

Patient Safety

Research& Evidence

Mental Health

Medical Device Safety

Safe Child Birth

Radiation Safety

WASH

Staffing & Personnel Safety

Advocacy and Leadership

Policy and Governance

Reporting & Learning System

Assessment & Measurement

Education and Training

Policy and Governance

Patient Safety Essential Functions

Leadership & Governance

Workforce & Safe Work Environment

Patient Engagement

Safe Clinical Care

Risk Management

RISK

Essential Function A

Leadership & Governance

Patient safety policy and implementation plan

Institutional framework for patient safety

Regulatory system and legislation

Clinical governance system

Independent assessment and accreditation

Work force & Safe Work Environment

Human resource norms and management

Professional education and in service trainings

Work environment and Ergonomics

Support services for patient safety

Physical and infrastructure safety

Essential Function C
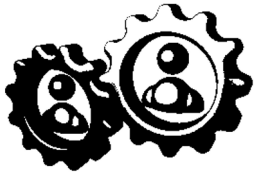

Patient Engagement

Patient centered care design

Information and Education of patient & families

Shared decision making
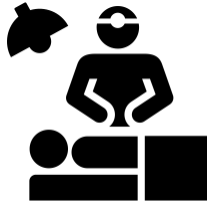
Evolving patient champions and groups

Communication, appraisal & redressal

Essential Function D

Safe Clinical Care

Safety of high risk clinical services

medication and medical devices safety

Infection Prevention and Control

Safety in transition of care

Patient safety in primary care

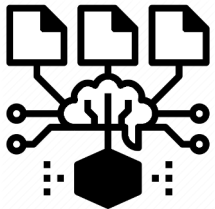Essential Function E

Risk Management

Reporting of errors and adverse events

Assessment, surveillance and research

Incident reporting integration

Learning and Response functions

Non punitive, voluntary and secured reporting

10

Dimensions of implementing patient safety

1

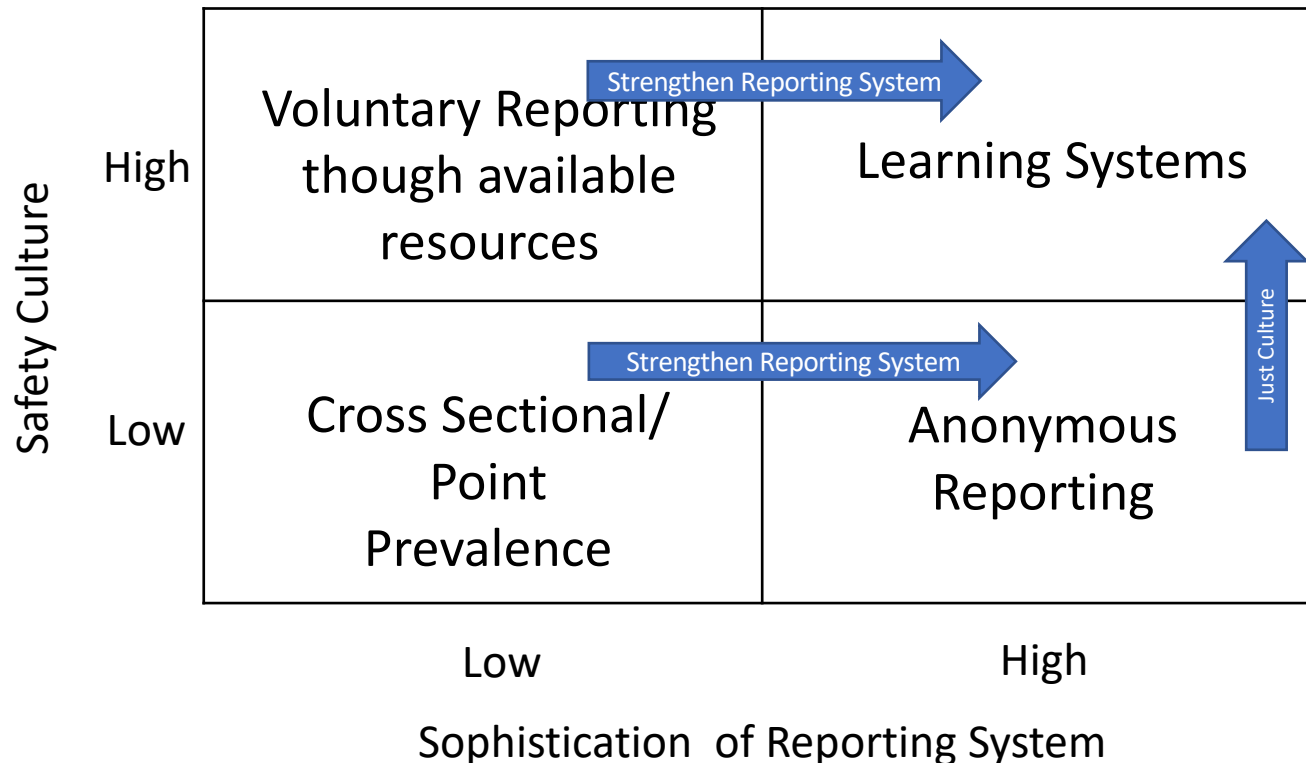Institute and operationalize patient safety teams

2

Promote 'blame free' and 'just' culture

3

Implement Reporting and learning system

Strategic Matrix for establishing reporting and measurement system

Safety Culture

	Low	High
High	Voluntary Reporting though available resources	Learning Systems
Low	Cross Sectional/ Point Prevalence	Anonymous Reporting

Strengthen Reporting System

Strengthen Reporting System

Just Culture

Low   High

Sophistication of Reporting System

Reporting and Learning System

International Classification for Patient Safety

Minimal Information Model for Patient Safety Incident Reporting and Learning Systems

USER GUIDE

World Health Organization

Conceptual Framework for the International Classification for Patient Safety
Version 1.1

Final Technical Report
January 2009

World Health Organization | Patient Safety
A World Alliance for Safer Health Care

4

Define and implement patient safety standards

5

Implement risk assessment and mitigation mechanism

6

Implement Standard Treatment Guidelines

7

Promote Patient & Family Engagement

8

Implement patient safety metrices

Sources and Limitations

Methods	Challenges
Retrospective record review	Requires good quality record keeping Resource intensive
Incident Reporting (RLS)	Voluntary in nature , Underreporting , extreme cases not reported
Routine hospital data	Administrative data may not have much information on medication use unless total digitalisation of patient records
Insurance claims and complaint	Would work only in systems has extensive insurance coverage. Won't give the full picture.
central national/regional audits or enquiries	Case and country specific. Not universal in nature
Modelling and extrapolation	Dependent on primary studies Risk of GIGO

Methods for estimating harm in data poor setups

- retrospective record review

- record review of current inpatients

- staff interviews on current inpatients

- direct observation and related interviews

- nominal group meetings

World Health Organization | Patient Safety — A World Alliance for Safer Health Care | RESEARCH — Better knowledge for safer care

Assessing and tackling patient harm

A methodological guide for data-poor hospitals

9

Implement human factors principles in design and service delivery

WHO's Flagship Global Patient Safety Challenges

First Challenge -2005
Clean care is safer care

Second Challenge -2007
Safe Surgery Save Lives

Third Challenge -2017
Medication without Harm

Thank you