





## Safe Healthcare

Dr J N Srivastava

Advisor – Quality Improvement

**National Health Systems Resource Centre** 



Safety isn't expensive, it's priceless.



### **Patients' Expectations**



### • Cure

- Correct, speedy, low cost, lasting treatment
- Emergency care
- No new disease
- No harmful procedure/ complication
- Care
  - Psychological well being & courteous behaviour
  - Clean, inviting atmosphere
  - Personalised approach

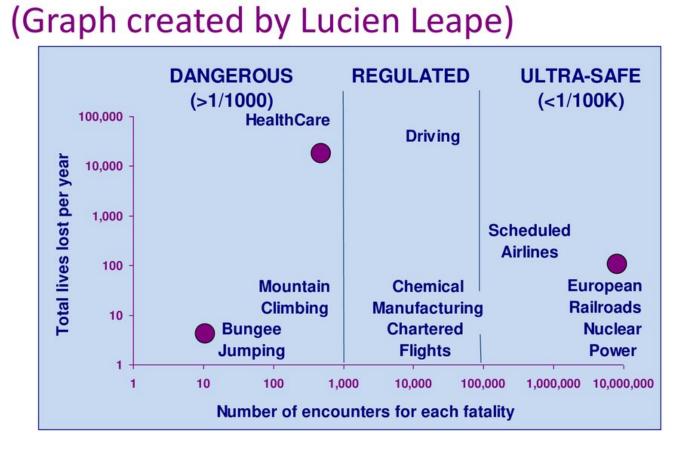




### **How Safe is Health Care?**



## How Do We Compare?











- Occurrence of adverse events due to unsafe care is likely to be one of the 10 leading causes of death & disability.
- 70 Lakhs\* surgical patients suffer significant complications each year, resulting into death of 10 Lakh such patients
- 1.7 Lakhs\* admissions annually in USA due to Patient harm
- 15% of hospital expenditure on treatment of safety failure in OECD countries
- 50% of such harm is preventable

\*1 million = 10 lakhs





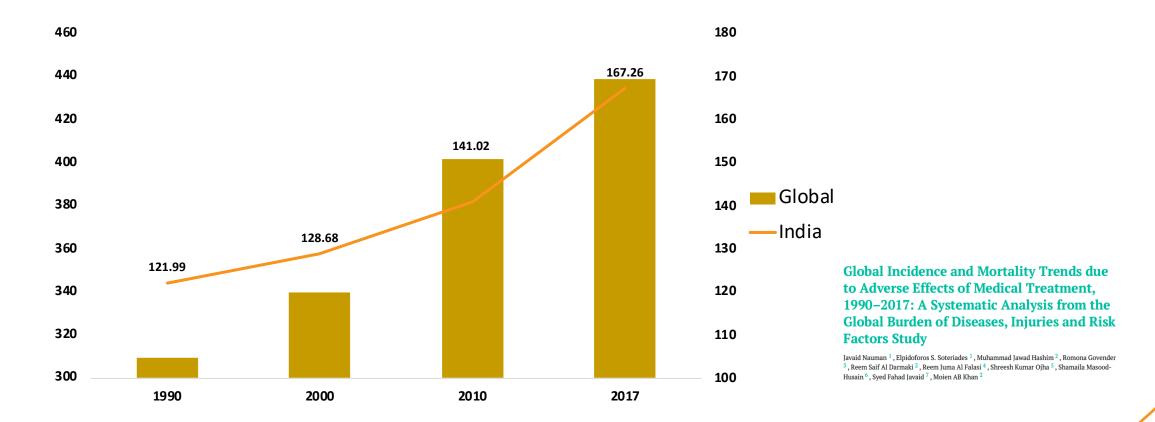
### **Indian Scenario**

- □In India around 5.2 million injuries occur due to medical errors, resulting in around 3 million preventable deaths every year.
- □For every 100 Hospitalization, approx. 12.7 adverse events occur.
- (Ashsih Jha, BMJ Quality & Safety, Sept 2013)



# Global age-standardized incidence rates per 100,000 population due to AEMT





Adverse Event of Medical Treatment (AEMT): "unintended injury due to medical care leading to an extended hospital stay, disability at the time of discharge, serious and devastating long-term irreversible consequences or death".



### **Patient Safety-Multiple facets**



**Medication Safety** ٠ **Reporting and learning** Medical Device Safety Safety culture ٠ Infection Prevention and Control ٠ Patient engagement ٠ Falls ٠ **System** Competence based training Patient identification Issues Leadership and governance ٠ Bed sores ٠ Human Factors and Venous Thromboembolism Ergonomics Personal Protection Safety Surveillance ٠ Injection Safety ٠ **Psychological Safety Environ-**Diagnostic safety ٠ Disaster preparedness mental Clinical Sepsis ٠ Issues Issues Communication during transition ٠ of care Radiation safety Fire Safety ٠ Safety in mental health care ٠ Electrical safety • **Blood** safety ٠ Structural Safety ٠ Surgical Safety Hygiene and Environment Anaesthesia safety ٠ Seismic Safety • Illumination . Infectious waste management •





### **Three Common Safety Incidents**

Related to Surgical Procedures (27%)
Medication Errors (18.3%)
Healthcare Associated Infections (12.2%)



- National Quality Assurance Standards
- 'Kayakalp' Initiative Infection Control, Needle Stick Injury
- National Patient Safety Implementation Framework
- Pharmacovigilance Programme of India Medication Safety
- Haemovigilance Programme of India Blood Safety
- Health Management Information System (HMIS) SSI, Needle Stick Injuries, Performance of Health Facilities (ALS, BOR), Audits, etc.
- Facility Level Audits MDR, CDR, Death Audits, Prescription audits

### FACILITY LEVEL QUALITY TEAM DISTRICT QUALITY ASSURANCE COMMITTEE STATE QUALITY ASSURANCE COMMITTEE CENTRAL QUALITY SUPERVISORY COMMITTEE



LaQshya हिंही किंही LAQSHYA लक्ष्म



Patient Safety

### NATIONAL QUALITY ASSURANCE PROGRAMME





#### NATIONAL QUALITY ASSURANCE PROGRAM

#### NQAS (DH/CHC/PHC/UPHC/CLMC/AEFI/HWC)

Certification..



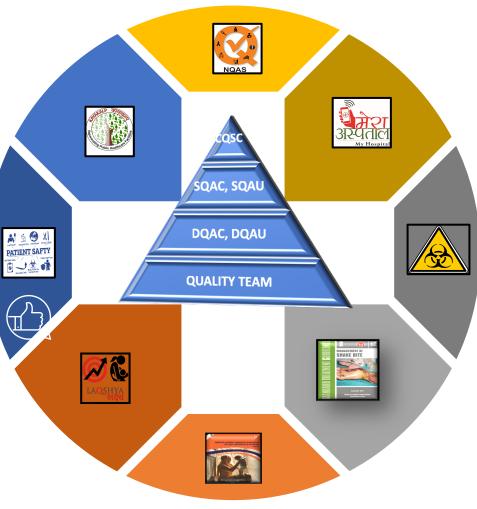
sanitation, hygiene, infection control and BMW management

#### **PATIENT SAFETY**

Patient Safety Implementation Framework Patient safety standards

#### LAQSHYA

Improve QOC around birth. Respectful maternity care



#### **MERA ASPTAAL**

An IT based application to measure and improve Patient satisfaction..

#### **BIOMEDICAL WASTE MANAGEMENT**

Implementation and monitoring Monitoring committees. at districts .

#### STANDARD TREATMENT GUIDELINES

Formulation and dissemination.

#### **AEFI**

Surveillance Standards. Certification

### Patient Safety : An Integral Part of NQAS systems

Physical Safety



Infrastructure Safety, Electrical Safety, Fire Safety, Diester Management, Secure & comfortable Environment for Staff, Visitors & Patients

Patient Identification, Identification of high risk & vulnerable patients, Identification & continuity of care of during transition & referral



Patient Identification

**Procedure** 

Safety

Medication Safety



Rationale prescription, Safe drug administration, medication reconciliation, review & optimization

Promoting Safe clinical processes, Use of safe surgery checklist, safe anaesthesia checklist & safe birth checklist, etc.

## Patient Safety : An Integral Part of NQAS systems

Screening of donated blood, compatibility testing, Adverse reaction associated with blood transfusion.

Reporting of HAI, HAI surveillance, Hand hygiene, Use PPE, Instruments processing, Environmental safety, Bio medical waste management



Health Care Associated infections

Risk Management

**Blood Safety** 



Risk management framework & plan, identification of existing & potential risks, risk assessment, reporting, evaluation and its mitigation as per plan

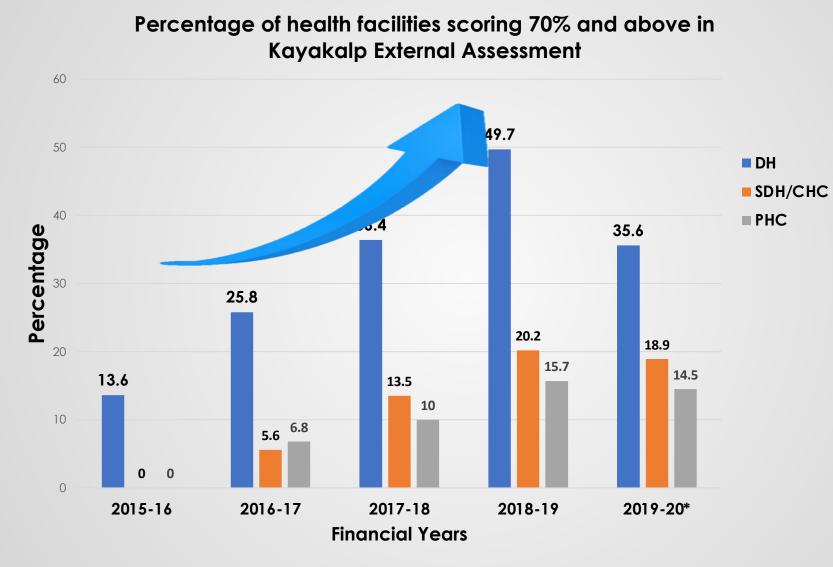
Staff protection from infections, radiations and other Hazards, provision of medical check ups, immunization, prophylaxis, etc.

**Staff Safety** 

### Patient Safety components under National Quality Assurance Standards (NQAS)



### Making Progress - Kayakalp



\* Result incomplete

JMP Report (WHO & UNICEF) 2019 – 97% DHs have some form of waste management facilities. 76% DHs have full system of BMW mgt.



### NPSIF Released on 19<sup>th</sup> April 2018







### **NPSIF – Strategic Objectives**



Establishing Institutional Framework



Infection Prevention & Control



Assessment & Reporting of Adverse Events



Safety in Programs and Clinical Domains



Competent Healthcare Workforce



Patient Safety Research

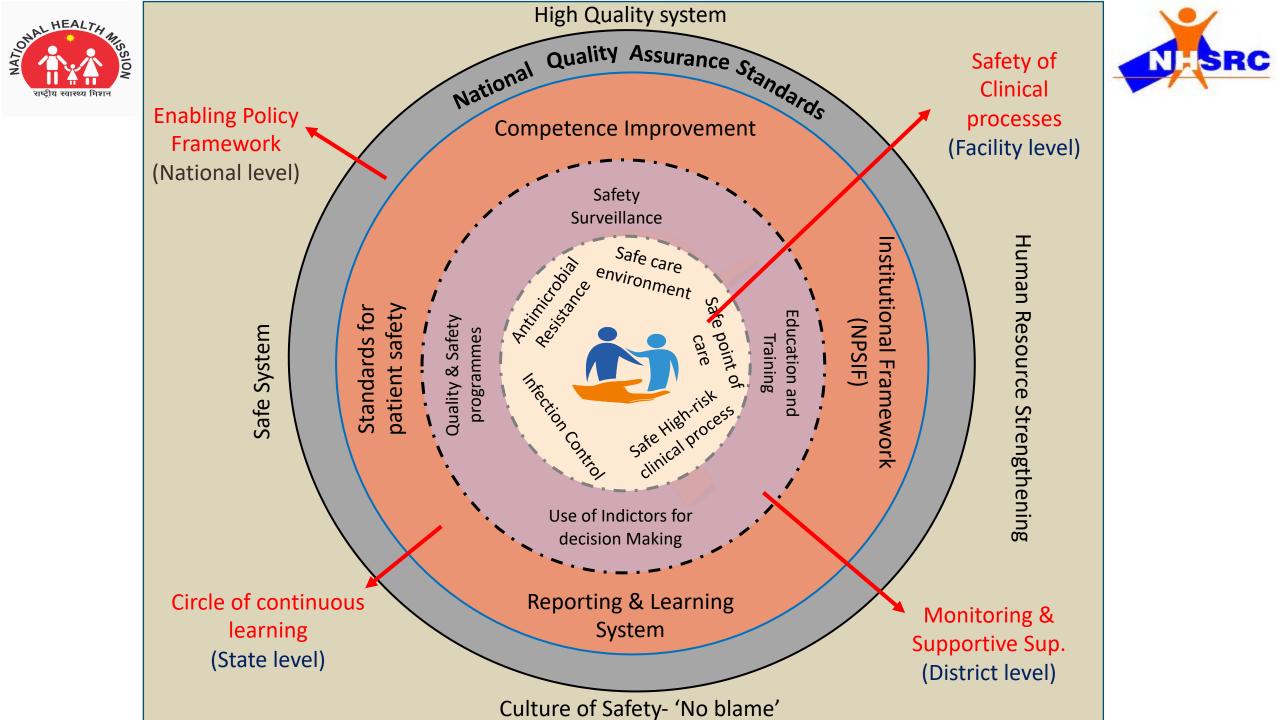






### Health Worker Safety: A Priority for Patient Safety

- Ensuring Availability of PPEs and Masks
- Helpline
- Insurance for Rs. 50.00 Lakhs
- Chemoprophylaxis for Frontline staff
- Ordinance to prevent the violence









- Culture Change shift from punitive to 'Just' culture
- Creating Enabling Environment
- Robust Learning & Reporting System
- Health system-based approach in addressing safety issues



Let's commit together for building SAFETY across health systems!!

# Thank you

"To err is human, to cover up is unforgivable and to fail to learn is inexcusable"

Sir Liam Donaldson