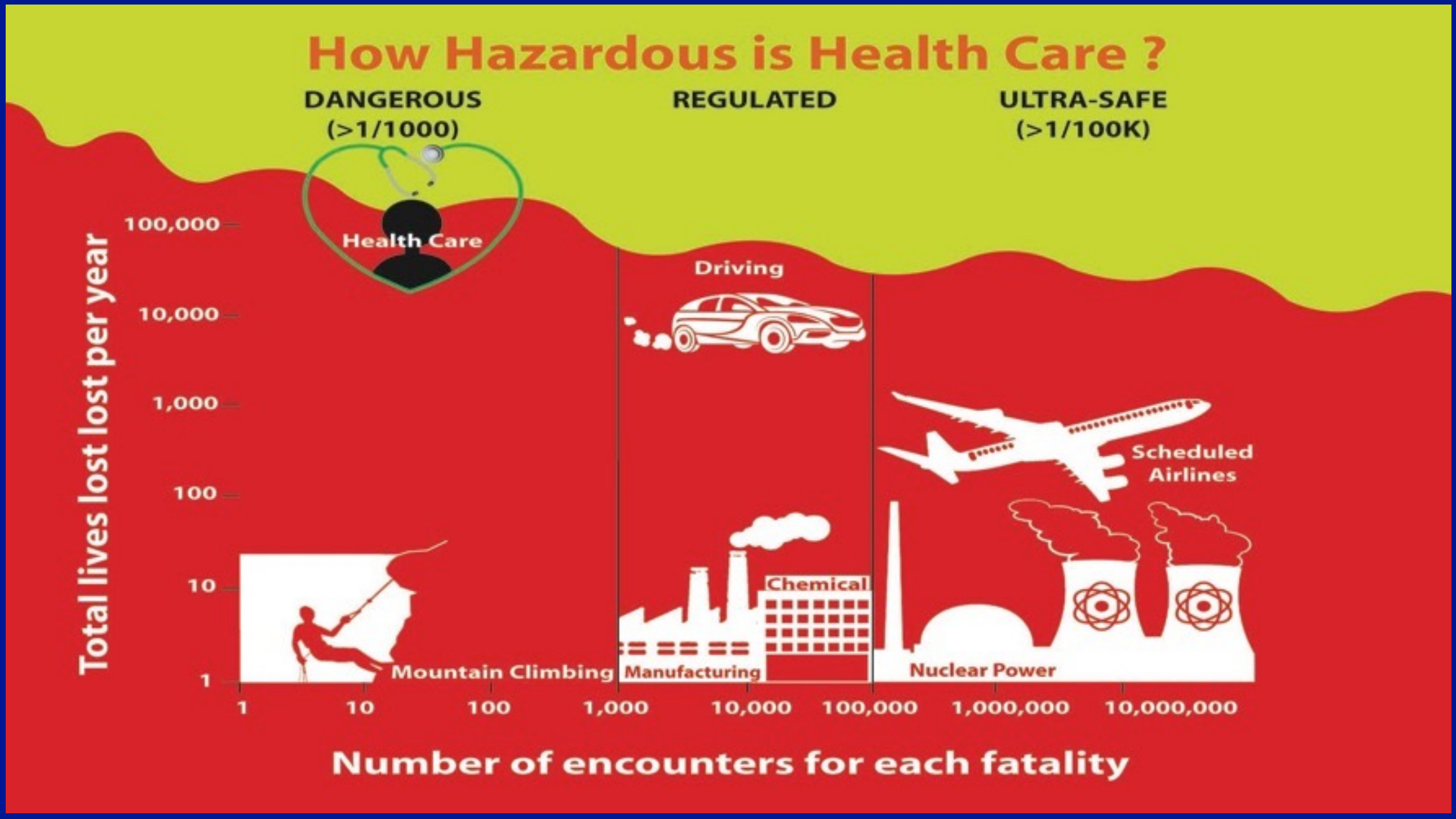
Overview of SaQushal Initiative

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

I didn't want to disturb you when you were working, sir.
But it is this leg which is injured!

How Hazardous is Health Care ?



“First do no harm.”

Hippocratic Oath

Patient Safety

According to WHO

- Patient safety is the absence of preventable harm to a patient during the process of health care and reduction of risk of unnecessary harm associated with health care to an acceptable minimum.
- An *acceptable minimum* refers to the collective notions of given current knowledge, resources available and the context in which care was delivered weighed against the risk of non-treatment or other treatment.

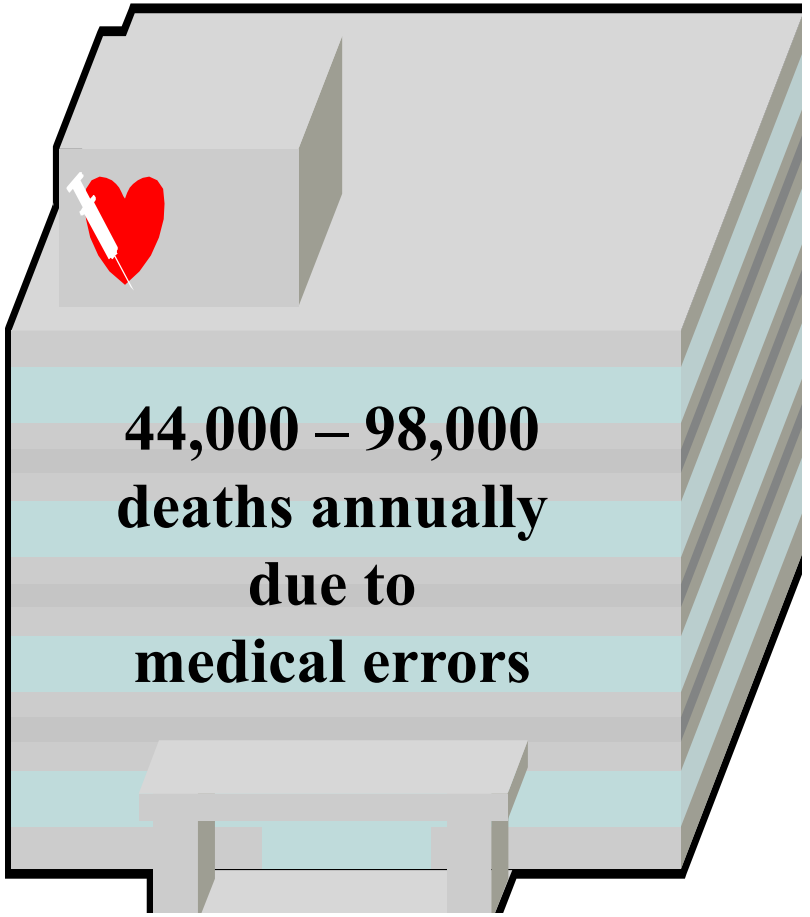
What about being a patient in the health care system

The Detroit News detnews.com

Extra Extra

Airlines expect 1-2 jets to crash daily

Over 1000 deaths expected weekly



NHSRC

Kohn et al. Committee on quality health care in America. IOM. Academy Press. 1999.

Global Burden

- 10% of drugs are either sub-standard or falsified - *Loss of 80 Lakhs DALY annually*
- Unsafe injections - 92 Lakhs DALY loss annually
- 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

In Europe - Every 10th patient experiences preventable harm or adverse events in hospital, causing suffering and loss for the patient, their families and health care providers.

In India,……..

Indian Scenario

- In India around 5.2 million injuries occur due to medical errors
- This makes medical errors one of the major causes of death.
- For every 100 Hospitalization, approx. 12.7 adverse events occur.

(Ashsih Jha, BMJ Quality & Safety, Sept 2013)

Burden of Unsafe Care (Comparative Analysis)

Patient Safety Concern	Global Context	Indian Context
Health Care Associated Infection	• Approx. 1.4 million patients suffer from HAIs at any time • Out of every 100 hospitalized patients, 7 in developed and 10 in developing countries acquire Health-care Associated Infections (HAIs)	According to study on device associated Infection rates in 20 cities in 2004-2013, prevalence of • 5.1 Central line-associated bloodstream infections (CLABSIs)/ 1000 central line days, • 9.4 cases of ventilator-associated pneumonia (VAPs)/ 1000 mechanical ventilator days &
Medication Safety	• 50% of all medicines are inappropriately prescribed, dispensed or sold,	• One of the studies conducted in 2016 in a tertiary hospital for medication error, documented a rate of 36%; out of which prescription error accounted for 65%

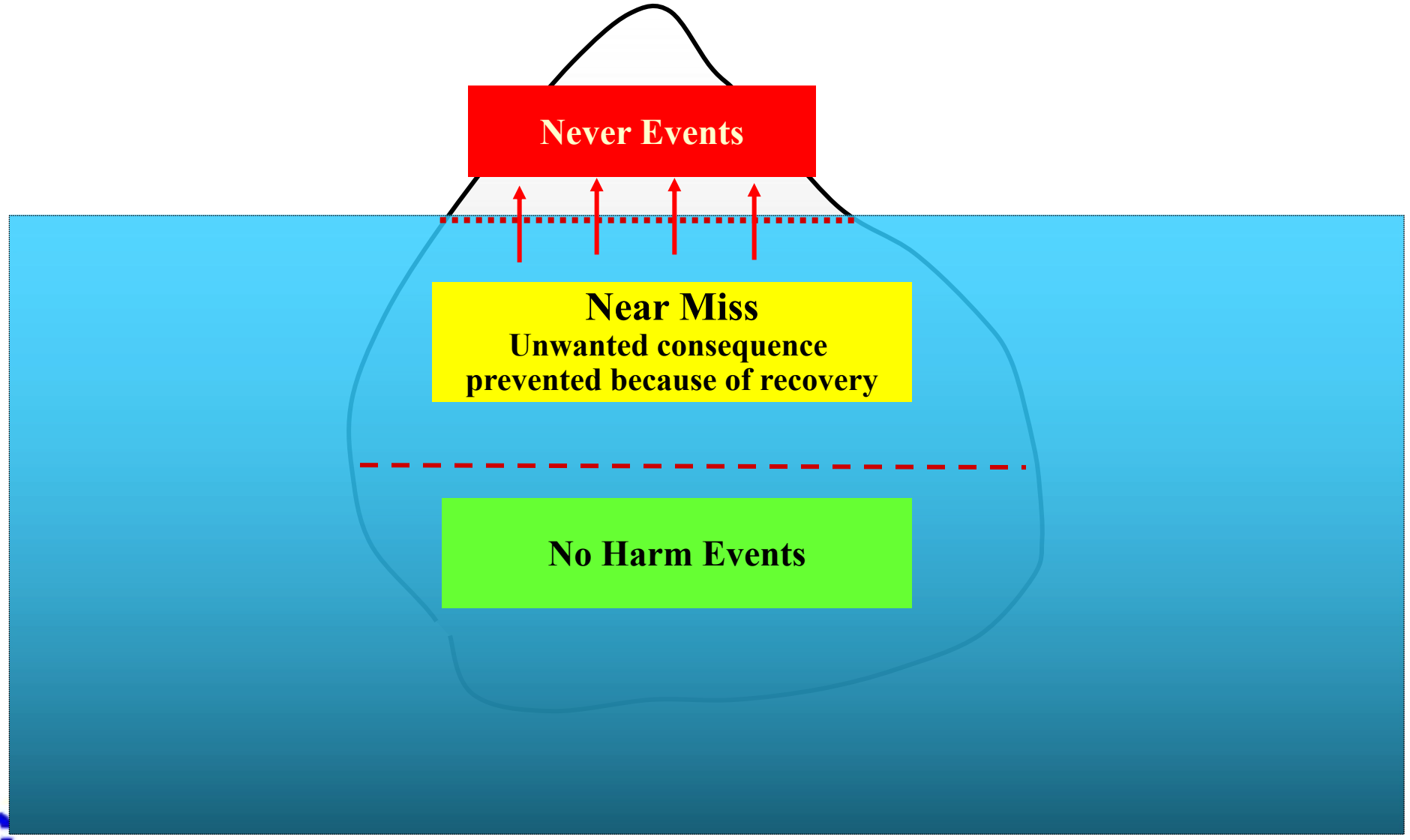
Burden of Unsafe Care (Comparative Analysis)

Patient Safety Concern	Global Context	Indian Context
Unsafe Injection Practices	• 22 Billion injections are administered every year • Due to unsafe injections practices, 9.2 million disability-adjusted life years lost per year	A study conducted by INCLEN in 2010 "Injection Practices in India"; out of administered three billion injections annually, 1.89 billion (62%) were unsafe injections
Blood Safety	As per WHO, 122 reporting countries out of 179 countries did screening of donated blood; • 99.6% high income countries • 81% LMIC • 66% in low-income countries	• 15 million units of blood required, but availability is only 11.8 million • From January 2013 to April 2016, a total of 3903 transfusion reactions were reported to the HvPI in 3807 patients
Patient Fall	Approx. 7 lakhs to 10 lakhs patients sustain fall in the hospitals in USA	
Communication Error	An European Commission project has found that handover communication is responsible for 25% to 40% of adverse events	In a study, • 24% of OPD patients documents contained the complete information (diagnosis, prescription and follow-up instructions) • 55% of patients received verbal follow-up and medication instructions

Three Common Safety Incidents

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

Iceberg Model of Accidents and Errors



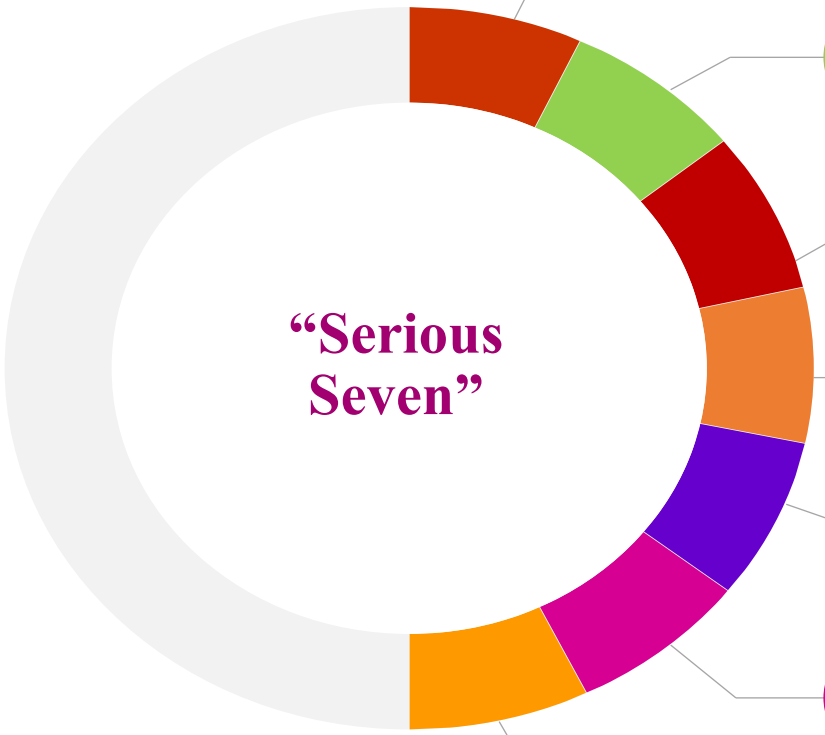
Never Events

Shocking medical errors that should never occur.

There are 29 ‘serious reportable events’ grouped into 7 categories

Never Events

It is termed as "Serious Seven" to emphasize the importance of prevention towards zero-occurrence.



01 Surgical or Procedural Event

02 Product or Device Event

03 Patient Protection Events

04 Care Management Events

05 Environmental Events

06 Radiologic Events

07 Criminal Events

1. Surgical events

1.1 Surgery or other invasive procedure performed on the wrong patient

1.2 Surgery or other invasive procedure performed on the wrong body part

1.3 Wrong surgical or other invasive procedure performed on a patient

1.4 Unintended retention of a foreign object in a patient after surgery or procedure

1.5 Intraoperative or immediately postoperative/post procedure death in Class I patient (ASA classification)

2. Product/ Device Events

2.1 Patient death or serious injury associated with the use of contaminated drugs, devices, or biologics provided by the health care setting

2.2 Patient death or serious injury associated with the use or function of a device in patient care, in which the device is used for functions other than as intended

2.3 Patient death or serious injury associated with intravascular air embolism that occurs while being cared for in a health care setting

3. Patient Protection Events

3.1 Discharge or release of a patient/resident of any age, who is unable to make decisions, to other than an authorized person

3.2 Patient death or serious disability associated with patient elopement (disappearance)

3.3 Patient suicide, attempted suicide, or self-harm resulting in serious disability, while being cared for in a health care facility

4. Care Management Events

4.1 Patient death or serious injury associated with a medication error (e.g., errors involving the wrong drug, wrong dose, wrong patient, wrong time, wrong rate, wrong preparation, or wrong route of administration)

4.2 Patient death or serious injury associated with unsafe administration of blood products

4.3 Maternal death or serious injury associated with labor or delivery in a low-risk pregnancy while being cared for in a health care setting

4.4 Death or serious injury of a neonate associated with labor or delivery in a low-risk pregnancy

4. Care Management Events

4.5 Artificial insemination with the wrong donor sperm or wrong egg

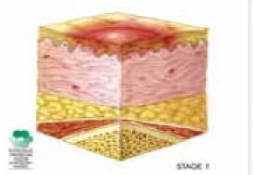
4.6 Patient death or serious injury associated with a fall while being cared for in a health care setting

4.7 Any stage 3, stage 4, or unstageable pressure ulcers acquired after admission/presentation to a health care facility

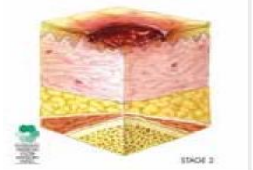
4.8 Patient death or serious disability resulting from the irretrievable loss of an irreplaceable biological specimen

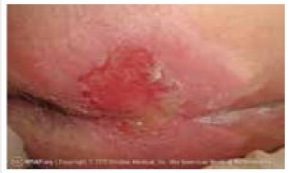
4.9 Patient death or serious injury resulting from failure to follow up or communicate laboratory, pathology, or radiology test results

Classification of Pressure Ulcer

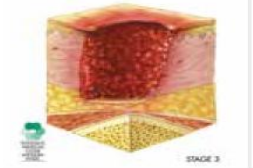


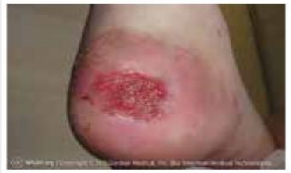
- **Category / Stage I:**
- Intact skin with non-blanchable redness of a localized area usually over a bony prominence. The area may be painful, firm, soft, warmer or cooler as compared to adjacent tissue.



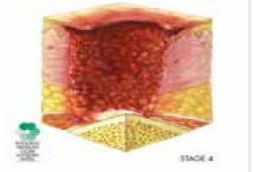


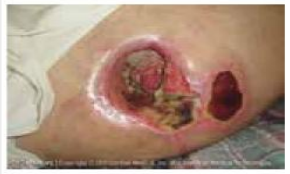
- **Category/ Stage II:**
- Partial thickness loss of dermis presenting as a shallow open ulcer with a red pink wound bed, without slough.



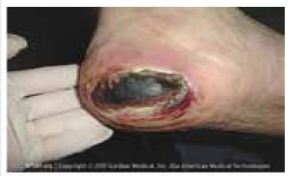


- **Category/ Stage III:**
- Full thickness tissue loss. Subcutaneous fat may be visible but bone, tendon or muscle are not exposed.





- **Category/ Stage IV:**
- Full thickness tissue loss with exposed bone, tendon or muscle. Slough or eschar may be present.



- **Unstageable/Unclassified: Full thickness skin or tissue loss – depth unknown**
- Full thickness tissue loss in which actual depth of the ulcer is completely obscured by slough. '

5. Environmental Events

5.1 Patient or staff death or serious disability associated with an electric shock in the course of a patient care process in a health care setting

5.2 Any incident in which a line designated for oxygen or other gas to be delivered to a patient contains no gas, the wrong gas, or is contaminated by toxic substances

5.3 Patient or staff death or serious injury associated with a burn incurred from any source in the course of a patient care process in a health care setting

5.4 Patient death or serious injury associated with the use of restraints or bedrails while being cared for in a health care setting

6. Radiologic Events

6.1 Death or serious injury of a patient or staff associated with introduction of a metallic object into the MRI area

7. Criminal Events

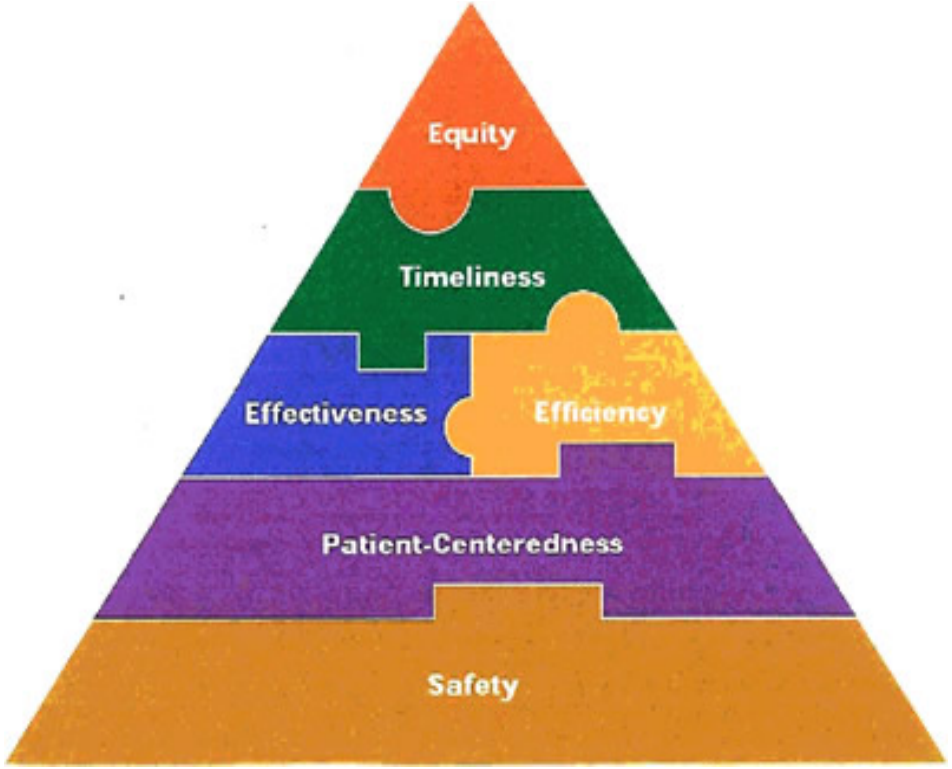
7.1 Any instance of care ordered by or provided by someone impersonating a physician, nurse, pharmacist, or other licensed health care provider

7.2 Abduction of a patient/resident of any age

7.3 Sexual abuse/assault on a patient within or on the grounds of a health care setting

7.4 Death or significant injury of a patient or staff member resulting from a physical assault (i.e., battery) that occurs within or on the grounds of a health care setting

Blocks of ‘Patient-Centric’ Quality of Care



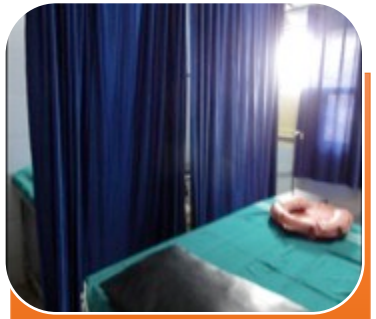
Quality of Care

*Source: Institute of Medicine

National Quality Assurance Standards
Areas of Concern (AOC)

Service Provision

Patient Rights



Inputs

Support Services

Clinical Care

Infection Control

Quality Management

Outcome

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

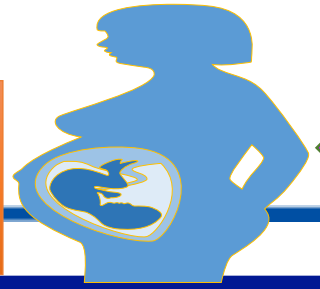
Patient Identification, Identification of high risk & vulnerable patients, Identification & continuity of care of during transition & referral

Patient Identification

Medication Safety

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

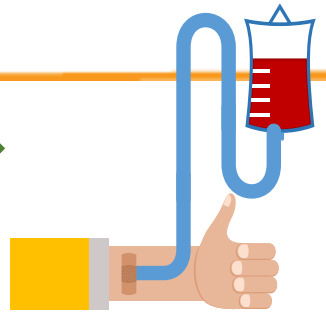
Promoting Safe clinical processes, Use of safe surgery checklist, safe anaesthesia checklist & safe birth checklist, etc.



Procedure Safety

Patient Safety : An Integral Part of NQAS systems

Blood Safety



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

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

NHSRC

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

Staff Safety

Patient Safety: An integral part of the National Quality Assurance Standards (NQAS)

AOC-A

- Availability of Services
- Time mandated

AOC-C

- Physical Safety
- Fire Safety
- Electrical Safety
- Competent HR

AOC-E

- Medication Safety
- Standard Treatment Guidelines
- Safe birth and Safe Surgery Checklist

AOC-G

- Audits
- Patient Satisfaction
- Internal & External Quality Assurance
- Risk Management

AOC-B

- Informed Consent
- Disable-friendly facilities
- Ethical issues

AOC-D

- Facility upkeep
- Equipment Calibration
- Safe and Secure environment

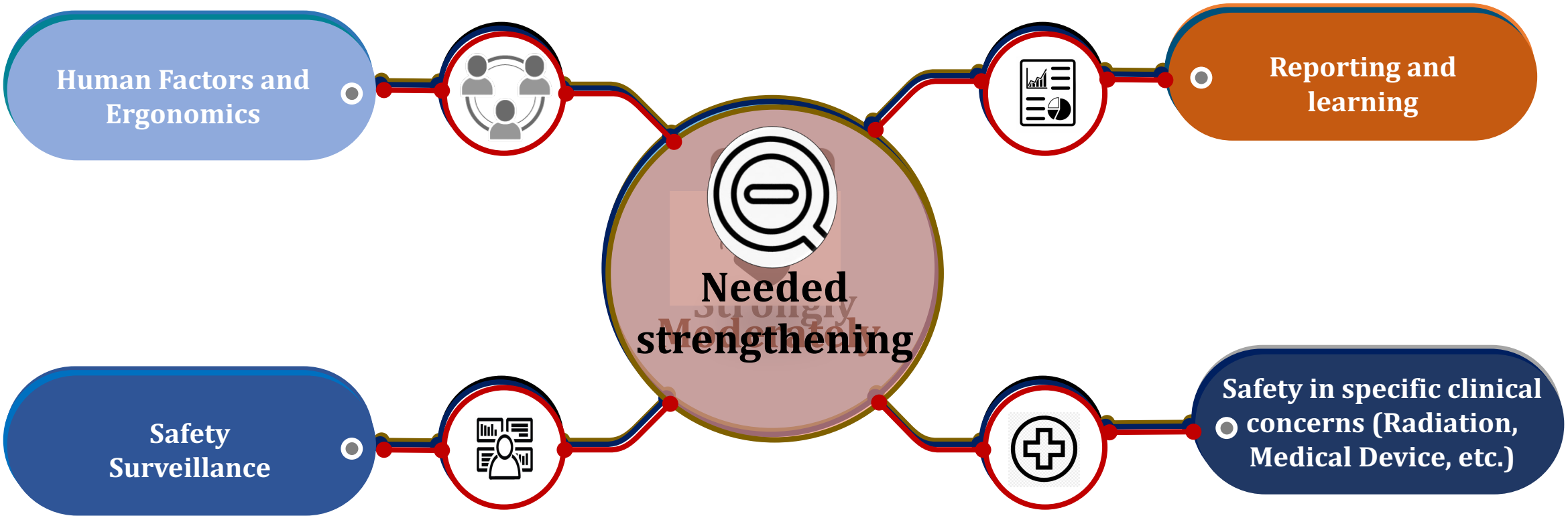
AOC-F

- Infection Control Practices
- Needle-stick injury
- Biomedical Waste Management

AOC-H

- Outcome of Clinical Care irt. Quality and Safety
- Key Performance Indicators

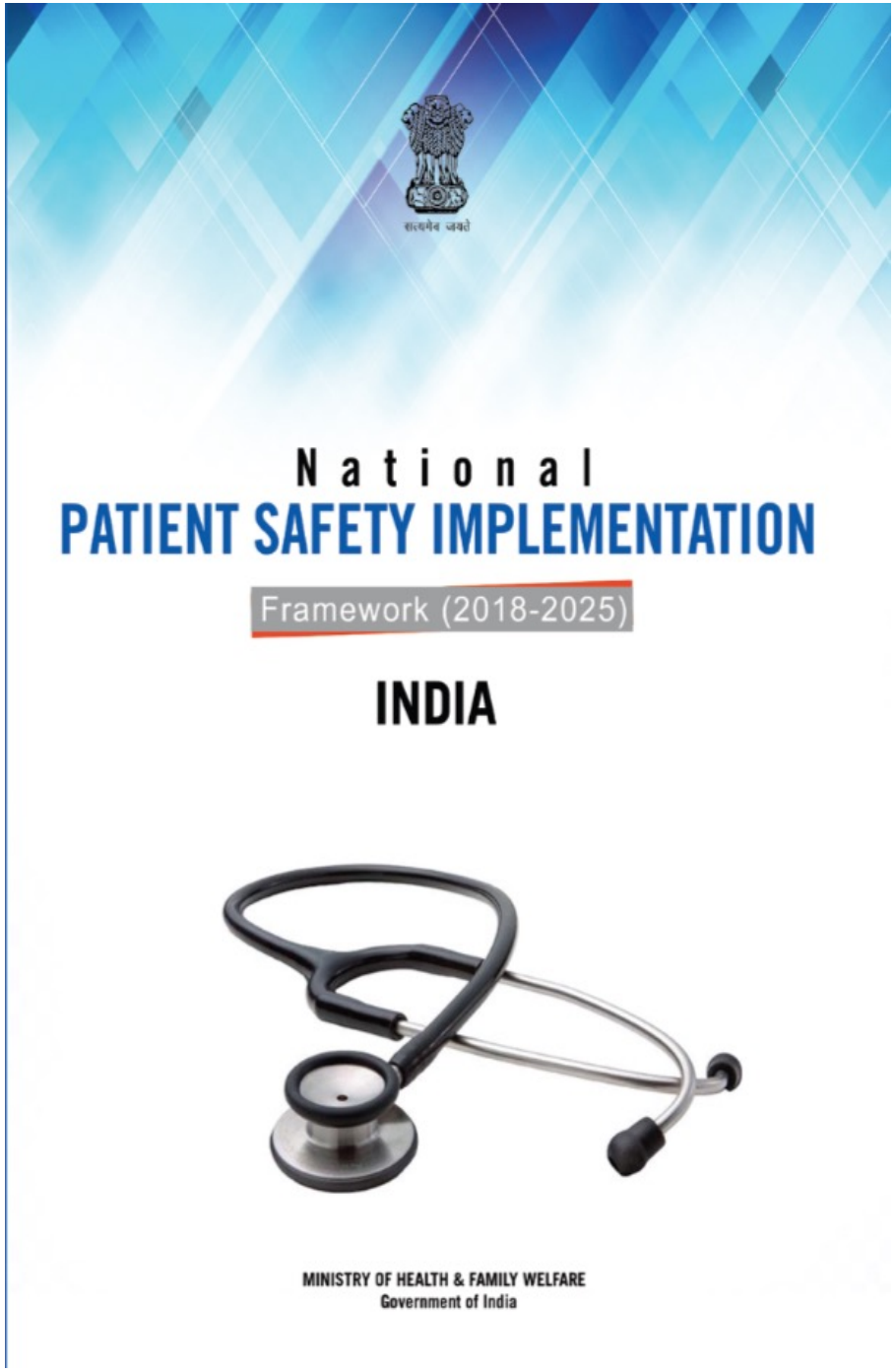
Patient Safety components under National Quality Assurance Standards (NQAS) before SaQushal



Need for Patient Safety Self-Assessment Tool

- Strengthen and streamline the existing quality assurance certification process under the NQAS
- Establish a credible system for reporting of adverse events to monitor extent of patient safety issues and learn from them
- Proposed tool further strengthens with the incorporation of following components:

1. **Patient Engagement**
2. **Human Ergonomics**
3. **Healthcare Worker's Safety**
4. **Reporting & Learning System**
5. **Reliable Health System**
6. **Blame free Environment**
7. **Safety Culture**
8. **Ability at Point of Care**
9. **Patient Safety Indicators**



National Patient Safety Implementation Framework

NPSIF Released on 19th April 2018

Establishing Institutional Framework

Assessment & Reporting of Adverse Events

Competent Healthcare Workforce

NPSIF – Strategic Objectives

Infection Prevention & Control

Safety in Programs and Clinical Domains

Patient Safety Research

TASKS DEFINED UNDER NPSIF (2018-2025)

Priority areas	Interventions	Responsible organizations/ Institutions
1.2 Strengthen quality assurance mechanisms, including accreditation system	1.2.1 Development and commissioning of minimum patient safety standards and Indicators	MoHFW/ National Patient Safety Secretariat
	1.2.2 Incorporate selected Patient Safety indicators as key performance indicators within the Quality Assurance Program	NHSRC
	1.2.3 Incorporate selected Patient Safety indicators within the accreditation system for hospitals and laboratories, including entry level accreditation	NHSRC NABH/ NABL
	1.2.4 Introduce hospital performance monitoring/ ranking system based on number of indicators, including patient safety indicators	HMIS & NHSRC
	1.2.5 Establish Special Commission to declare "Patient Safe Healthcare Institution" based on adherence to defined standards (Quality Assurance, NABH, etc.)	MOHFW/DGHS
	1.2.6 Streamline accreditation programs for availing incentives in reimbursement benefits the insurance providers	NABH/NQAS/STATE STANDARD/ BIS/ IRDA/ RSBY
	1.2.7 Incorporate fire safety, seismic safety, device safety, structural safety of healthcare facilities into the existing Quality Assurance and Accreditation standards	NABH/NQAS/NATIONAL BUILDING CODE/state govt.
1.3 Establishing a culture of safety and improving communication, patient identification, handing over transfer protocols in healthcare facilities	1.3.1 Develop comprehensive communication strategy for Patient Safety, targeting different stakeholders	MOHFW/DGHS
	1.3.2 Streamline standardization of Patient Safety initiatives at different levels of care through SOPs, algorithms, checklists, etc. (link to Strategic Objective 5)	MOHFW/DGHS /NHSRC

Subsequently, a decision was taken by the NHSRC's Governing Body that separate certification against patient safety standards need not be undertaken

Instead, the existing NQAS framework could be strengthened by adequately incorporating the patient safety requirements

Therefore, a self-assessment tool is developed to support the health facilities in ensuring delivery of safe care


एवं परिवार
MINISTRY OF
LTH

SaQushal

Safety and Quality: Self-Assessment Tool for Health Facilities


स्वास्थ्य एवं परिवार कल्याण मंत्रालय
MINISTRY OF HEALTH
&
FAMILY WELFARE
ISRC INDIA (Cohost)

Arrangement of Self-Assessment Tool

Area of Concern

- Safe Patient Care Processes
- Clinical Risk Management
- Safe Care Environment
- Patient Safety Systems

Scope : Self-Assessment Tool

- All District hospital level facilities
- Later, at the facilities below District Hospitals, in a phased manner

Evolution of Global Patient Safety Movement

To Err is Human
1998

WHA Resolution
2002

1st Global Challenge
2005

2nd Global Challenge
2009

1st Global Ministerial Summit
2016

3rd Global Challenge
2017

WHA Global Action on patient safety
2019

Draft – Global Action Plan
2021-30

To Err is Human
- Landmark report ... patient safety
- Estimated around 98,000 people die in hospitals each year as a result of medical errors in USA

WHA55.18 – Quality of Care: Patient Safety
... Member States to pay the closest possible attention to the problem of patient safety.

Clean care Safer Care
First Global Patient Safety Challenge
5 Moments of Hand hygiene

Safe Surgery Save Lives
Second WHO Global Patient Safety Challenge

Global Patient Safety Ministerial Summit
- galvanize international policy and governmental actors to prioritize patient safety at all levels
- 1st London
- 4th Jeddah

Medication Without Harm
World Health Assembly
Third WHO Global Patient Safety Challenge
- Reduce the level of severe, avoidable harm related to medications by 50% over 5 years, globally

WHA resolution on Patient Safety
Global patient safety action plan
Minimum standards
Global coordination mechanism
Operational research

Global Patient Safety Action Plan 2021-2030

- January 2021: submitted to the 74th World Health Assembly in 2021 through the 148th session of the Executive Board
- May 2021: approved by the 74th WHA decision
- August 2021: formally launched

Seven Strategic Objectives

SO1
Policies to eliminate avoidable harm in health care

SO2
High-reliability systems

SO3
Safety of clinical processes

SO4
Patient and family engagement

SO5
Health worker education, skills and safety

SO6
Information, research and risk management

SO7
Synergy, partnership and solidarity

Strategic Objective 1

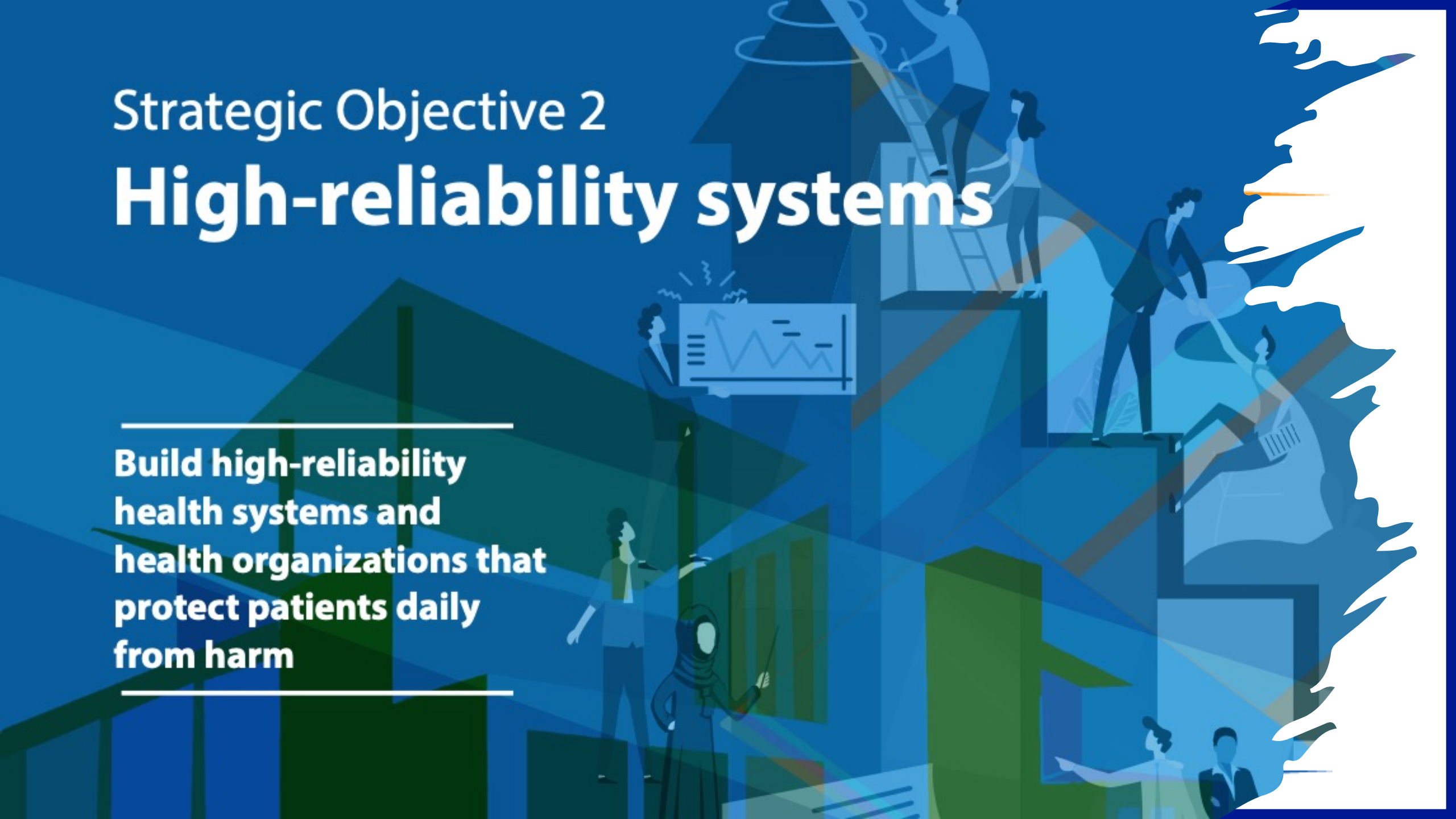
Policies to eliminate avoidable harm in health care

Make zero avoidable harm to patients a state of mind and a rule of engagement in the planning and delivery of health care everywhere

Strategic Objective 2

High-reliability systems

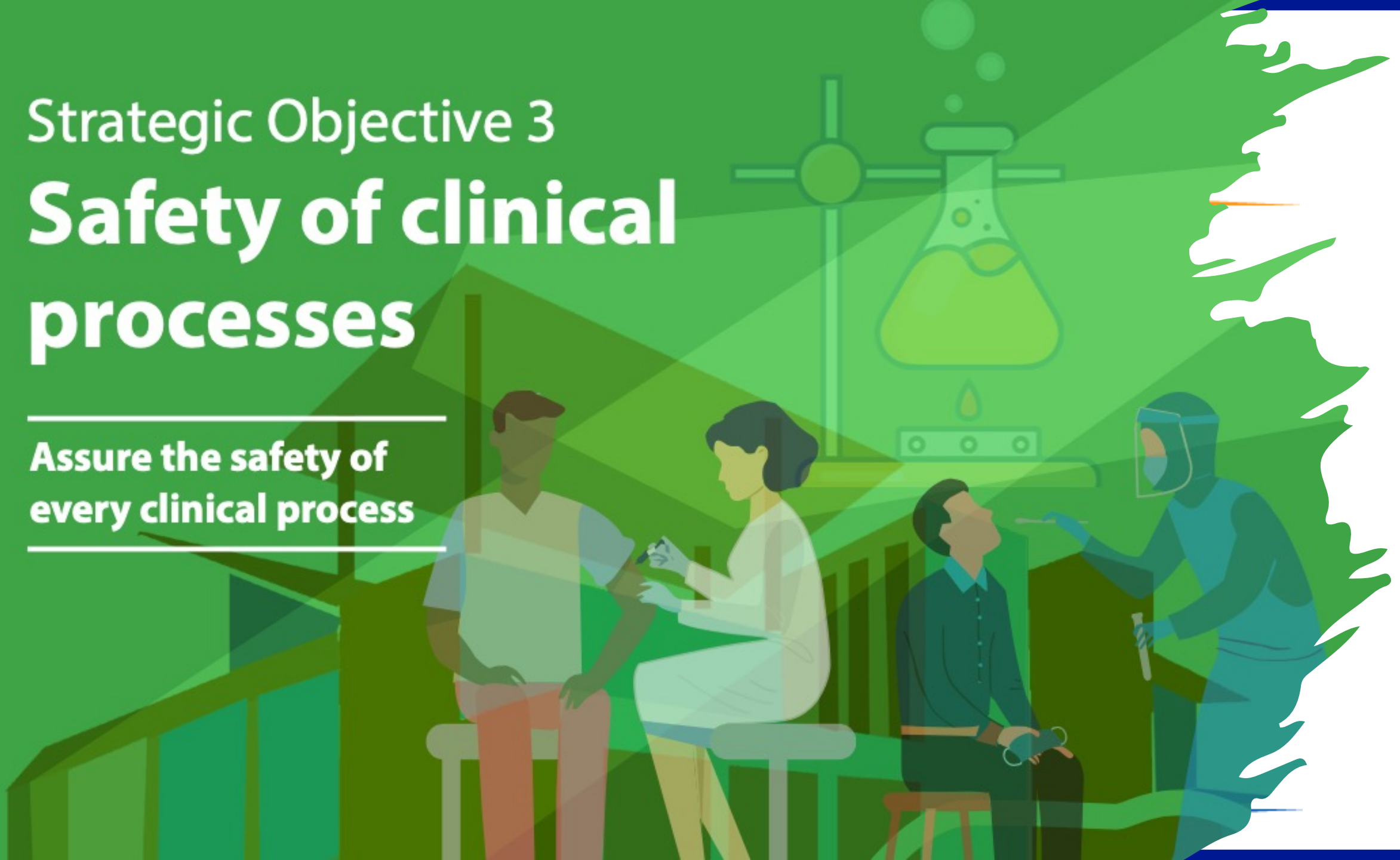
Build high-reliability health systems and health organizations that protect patients daily from harm



Strategic Objective 3

Safety of clinical processes

Assure the safety of every clinical process



Strategic Objective 4

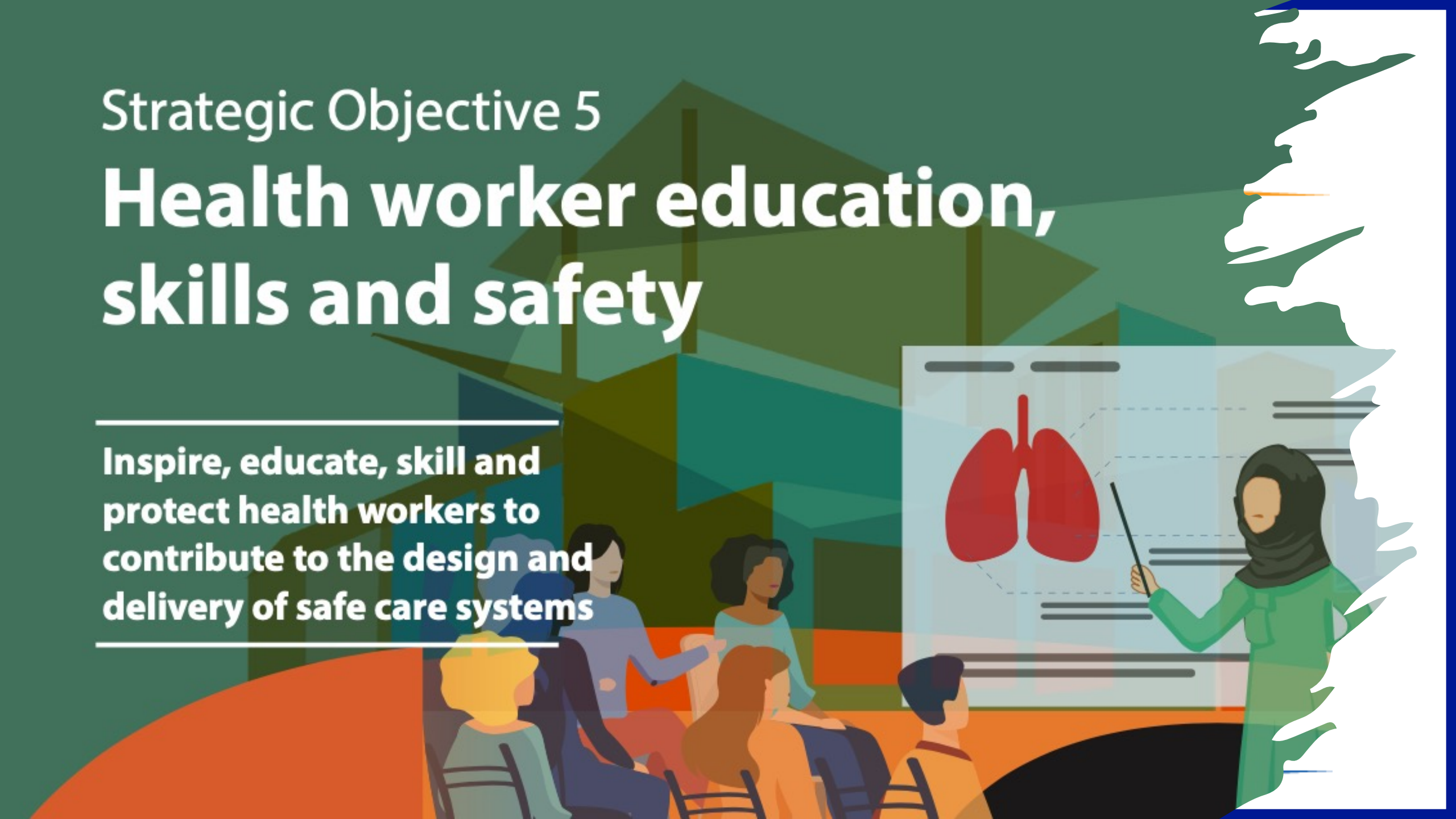
Patient and family engagement

Engage and empower patients and families to help and support the journey to safer health care

Strategic Objective 5

Health worker education, skills and safety

Inspire, educate, skill and protect health workers to contribute to the design and delivery of safe care systems



Strategic Objective 6

Information, research and risk management

Ensure a constant flow of information and knowledge to drive the mitigation of risk, a reduction in levels of avoidable harm, and improvements in the safety of care

Strategic Objective 7

Synergy, partnership and solidarity

Develop and sustain multisectoral and multinational synergy, partnership and solidarity to improve patient safety and quality of care

Seven Steps to Patient Safety

1. Lead and support your staff
2. Foster a culture of safety
3. Promote reporting
4. Involve patients and the public
5. Implement solutions to reduce / avoid harm
6. Learn and share safety solutions
7. Integrate your safety management activity

Adapted from: National Patient Safety Agency for the National Health Service

"Seven Steps to Patient Safety – An Overview Guide for NHS Staff"


capability
reporting
innovation
immunization
capacity
workforce
medical
prevention
competent
falls
culture
safety
radiation
Challenges
fragile
primary
conditions
Leadership
empowerment
continuum
processes
control
learning
patient
anti-microbial
workplace
compassionate
partnerships
hygiene
emergencies
Developing
quality
workforce
sanitation
universal
factors
education
Sufficient
surgery
products
medication
resistance
network
transfusion
Measurement
Global
research
surveillance
mental
injections
health
Water
policy
engagement
training
clinical
priorities
blood
Patient
Human
infection
thromboembolism
coverage
devices
care
venous
Patient
Safety

Thank you