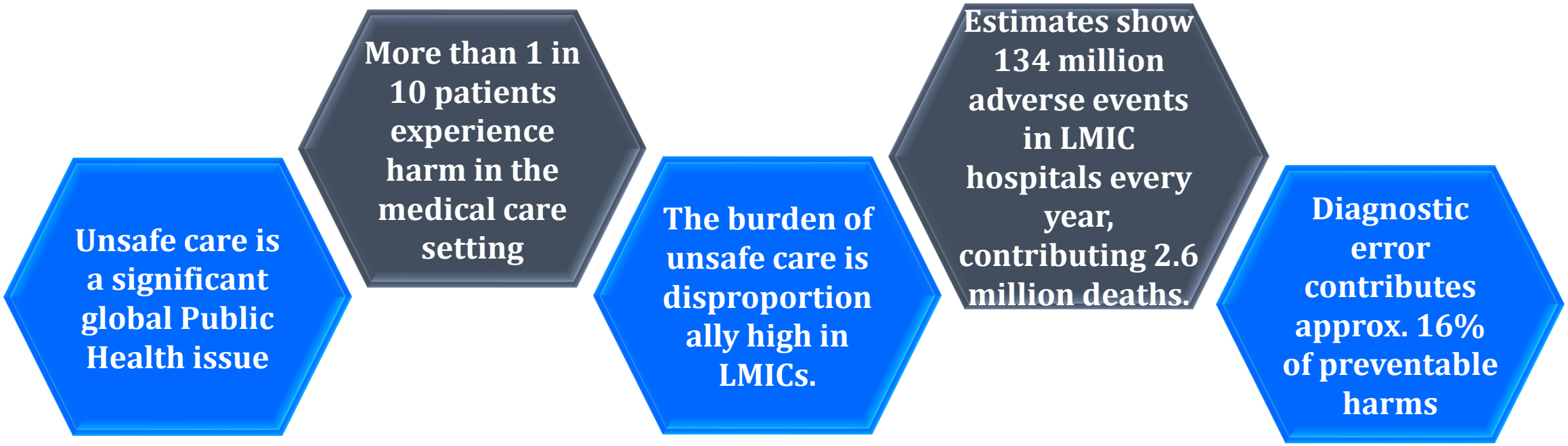
Ministry of Health and Family Welfare
Government of India

Analysis of SaQushal: Learning and Way Forward

Burden of Unsafe Care



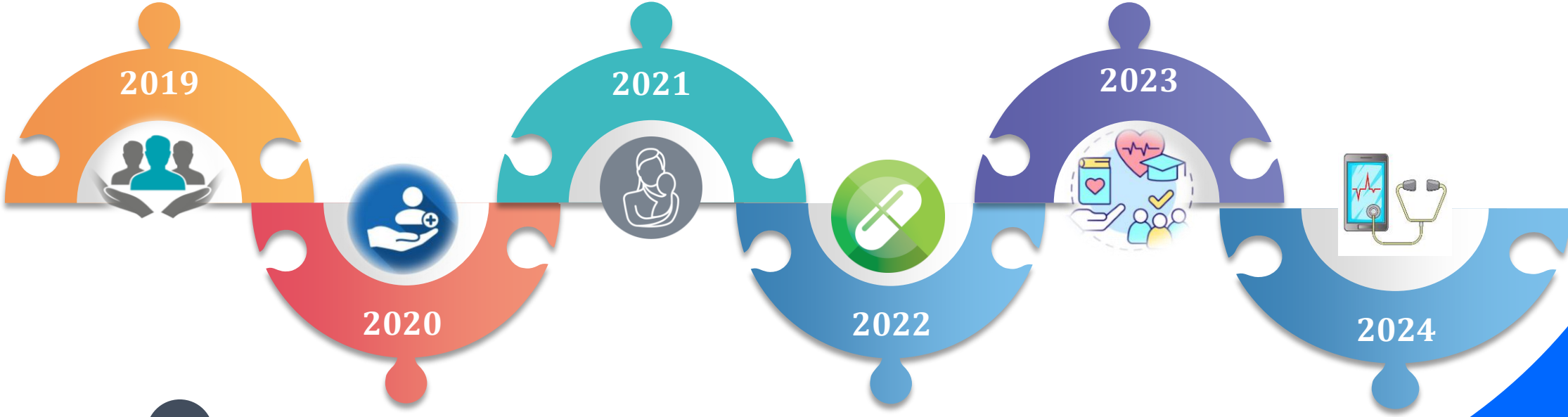
Global Patient Safety Report 2024: World Health Organisation .

Patient Safety Framework 2018-2025

- Improvement of structural systems for Quality and safety
- Assessment and reporting of adverse events
- Ensure a competent and capable workforce
- Prevent and control health-care-associated infections.
- Strengthening Patient Safety across all programmes.
- Promote patient safety research.

Journey for Patient Safety In India

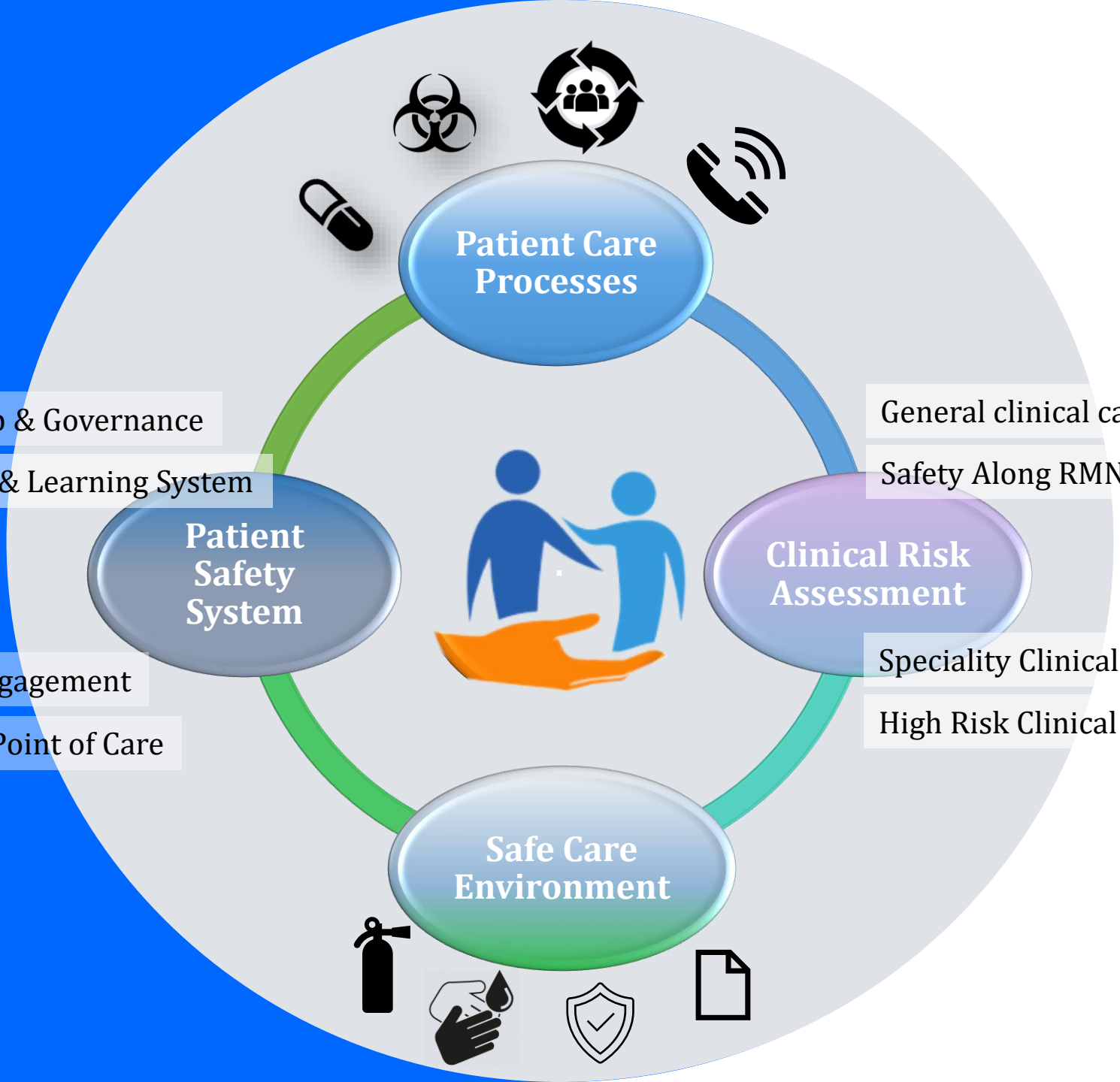
2019	2020	2021	2022	2023	2024
Organised webinar on importance of Patient Safety	- National webinar on Patient Safety - Pledge administration - Healthcare worker safety charter signed	- National webinar on Patient Safety - Launch of • Operational Guidelines 2021 • MusQan programme	-National webinar on Patient Safety - Launch of SaQushal Self-Assessment Toolkit	- National webinar on Patient Safety - Launch of IEC material on Patient Engagement - Recognition of pt safety champions	- National Celebration of World Patient Safety Day - Pt Safety Coffeetable 2023
1 Patient Safety: a global health priority	2 Health Worker Safety: A Priority for Patient Safety	3 Safe maternal and newborn care	4 Medication Safety	5 Engaging Patients for Patient Safety	6 Diagnostic Safety



SaQushal

Safety and Quality: Self-Assessment Tool for Health Facilities

- SaQushal was launched on World Patient Safety Day 2022.
- Self Assessment Tool which will assess the facility from a **patient safety perspective.**
- Applicable to **District Hospitals for now.**
- Builds staff capacity in patient safety through best practices and **involves patients and communities in decision-making.**



Leadership & Governance

Reporting & Learning System

Patient Engagement

Ability at Point of Care

General clinical care

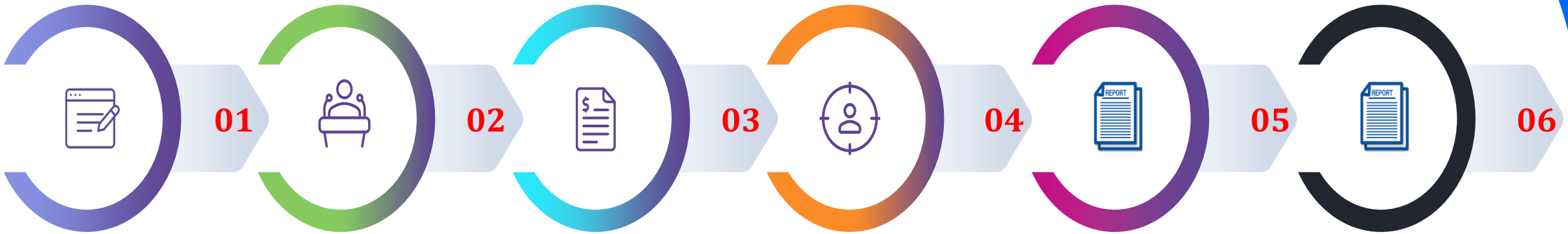
Safety Along RMNCHA

Speciality Clinical Services

High Risk Clinical Processes

Area of Concern

Conduct of the assessment at the facility



Assessment Plan & Schedule

Constitution of Assessment Team

Conducting Assessment

Conclusion & Scoring

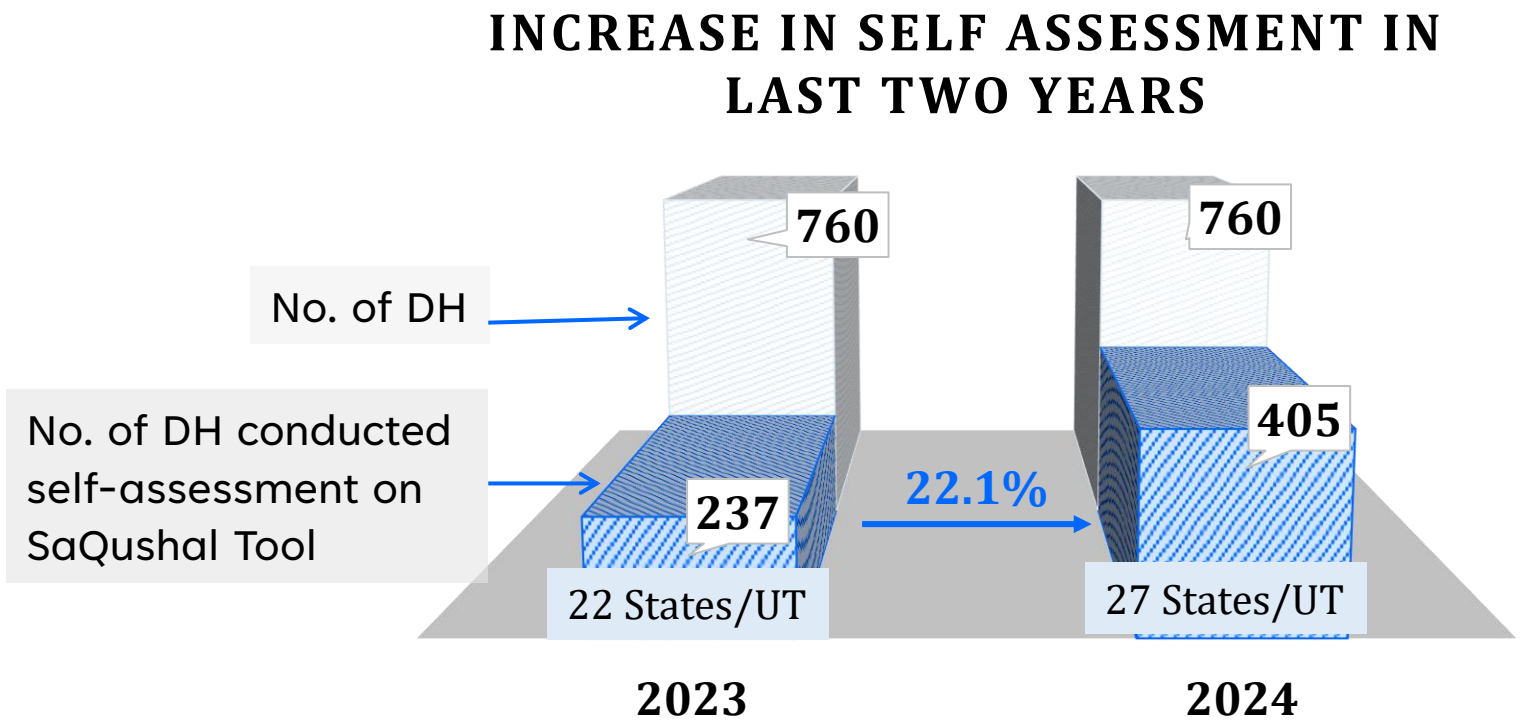
Review and Action Planning

Monitoring and Supervision

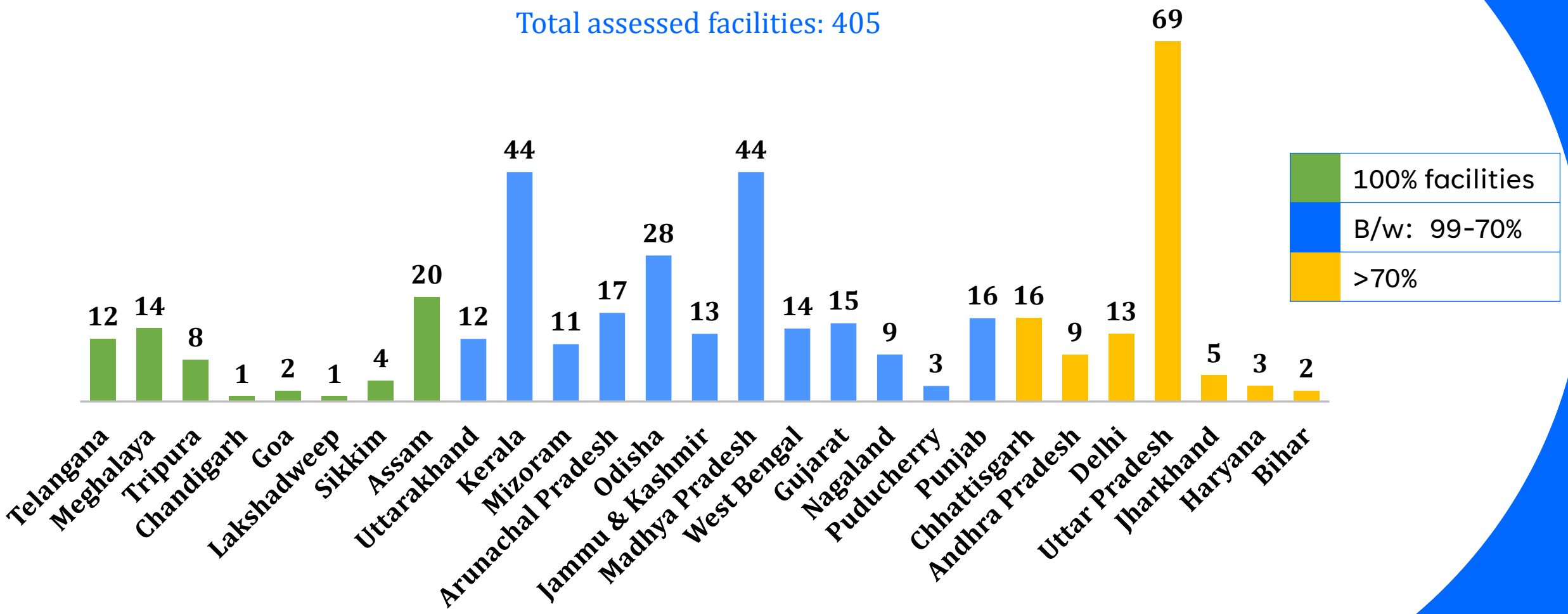
Activities on Patient Safety Day

Self Assessment of District Hospitals all over the country on the SaQushal Tool

Activity initiated in 2023

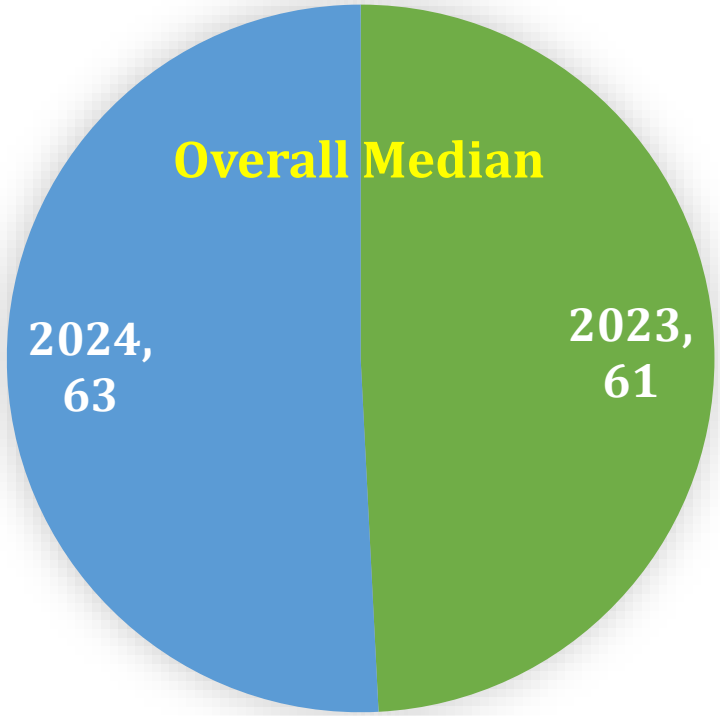


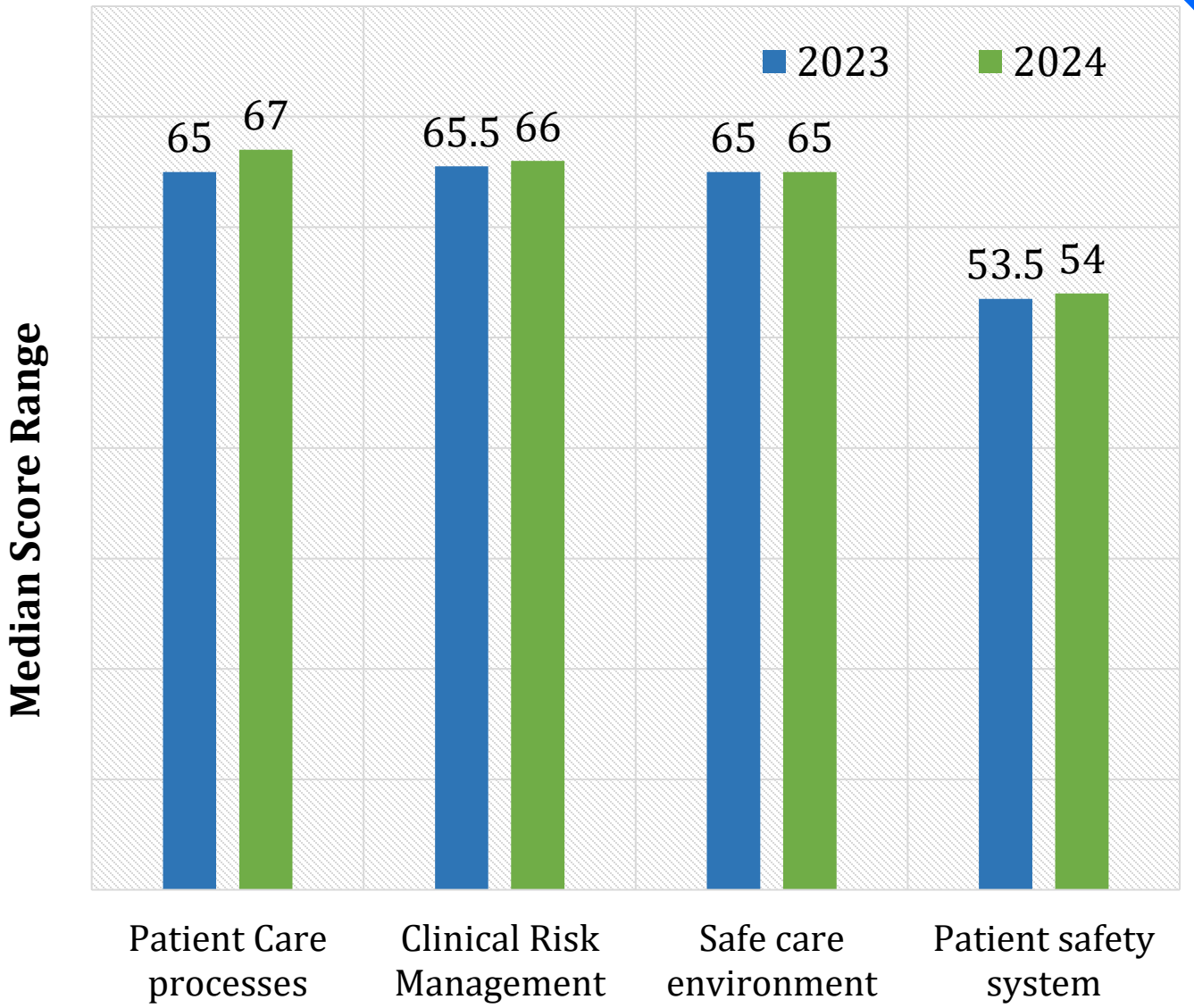
State wise DH Assessed under SaQushal



As of 12th September 2024, Data from 27 States/UTs

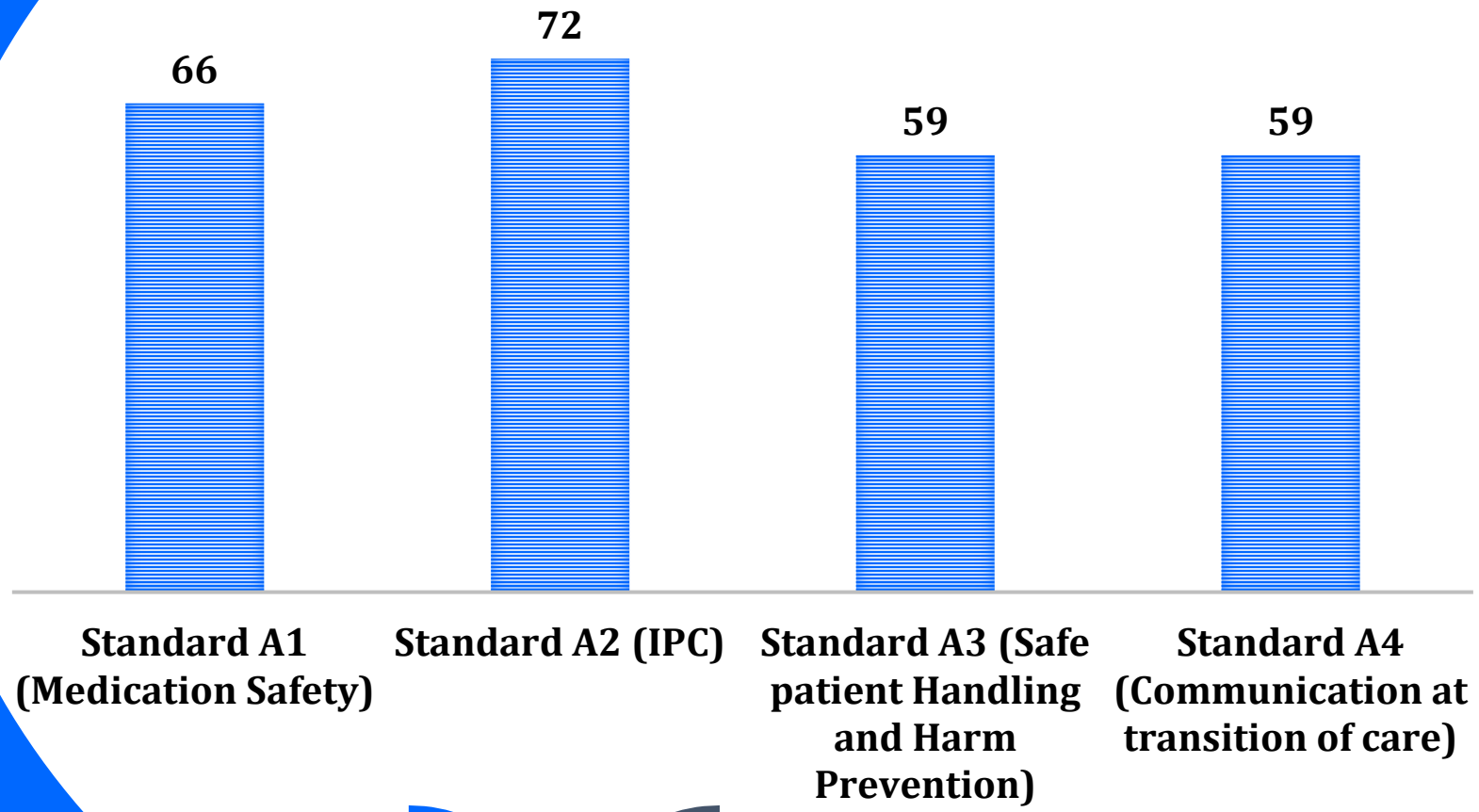
Comparative Analysis of Scores- 2023 & 2024



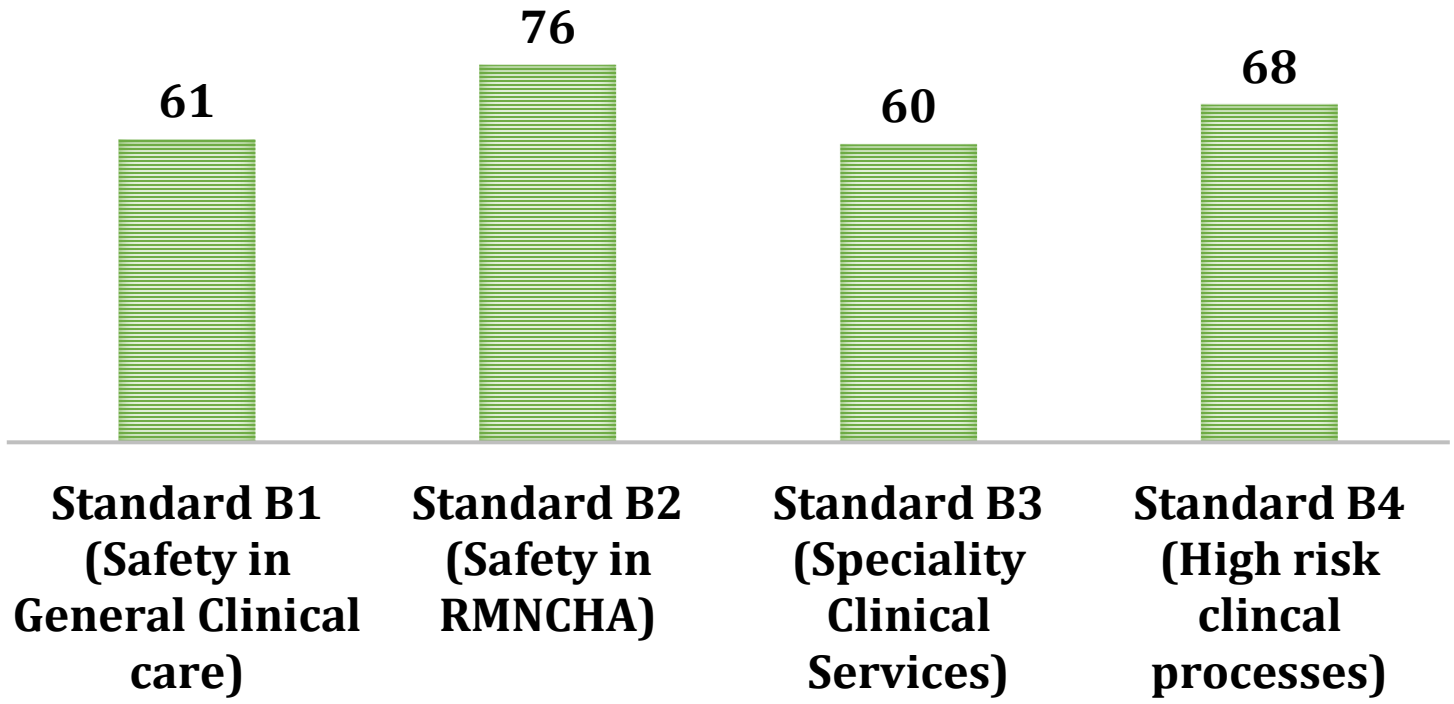


Total assessed facilities: Year 2024= 405 Year 2023= 237

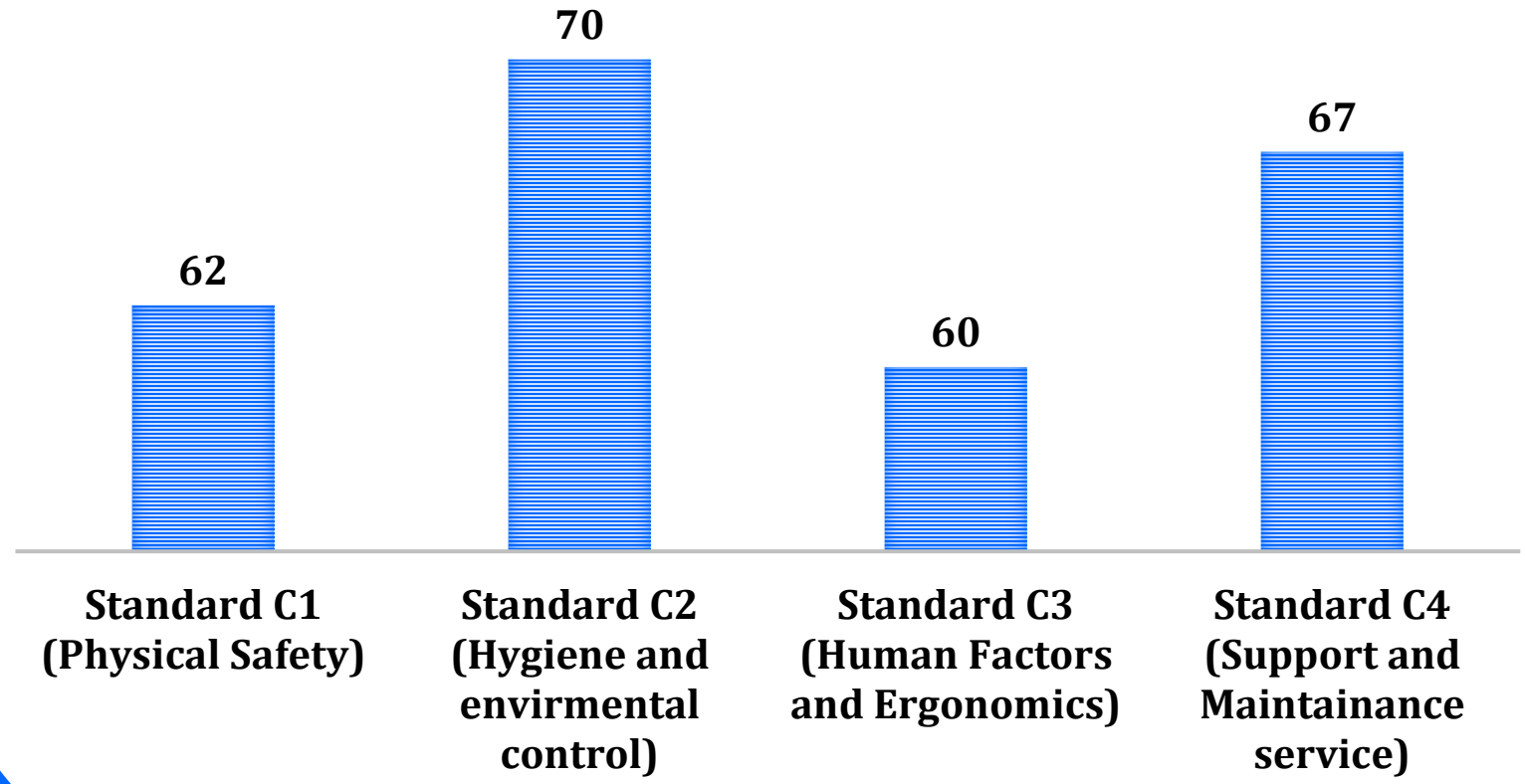
Scores of Area of Concern A (Patient Care Processes)



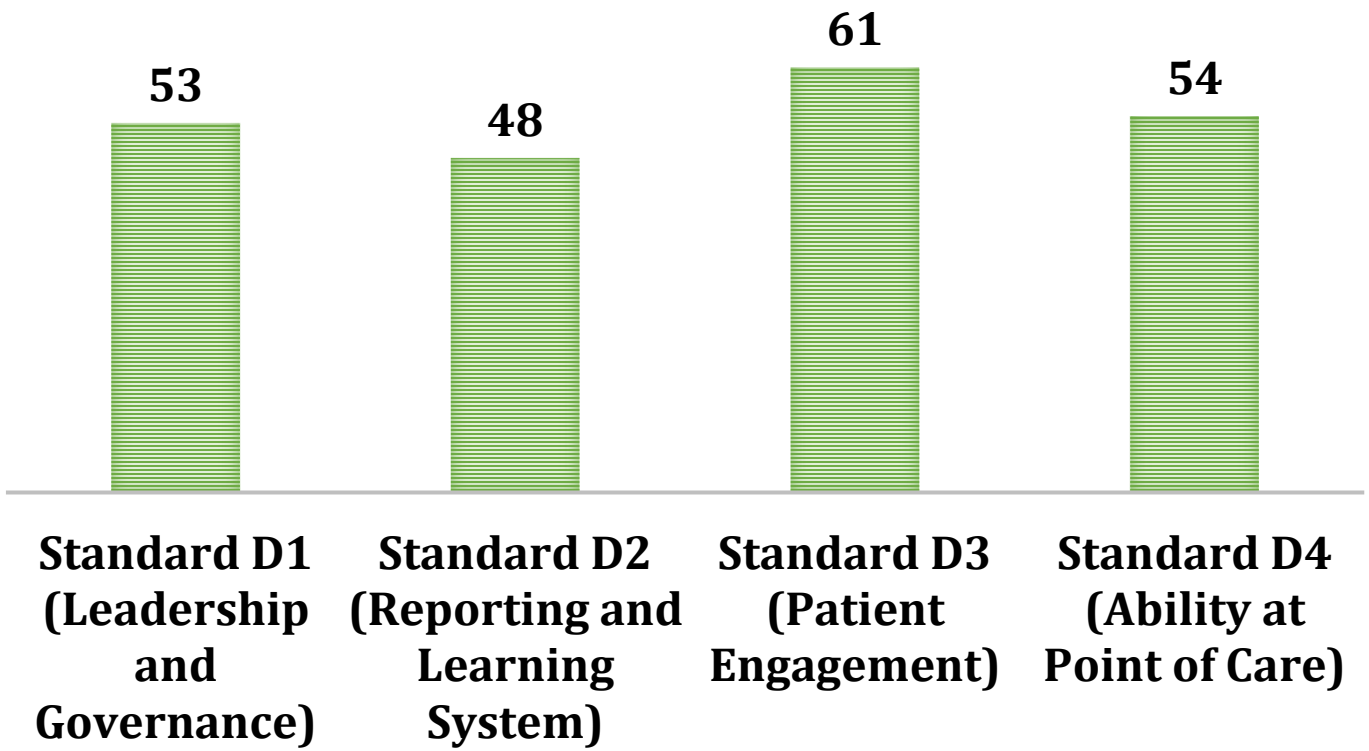
Scores of Area of Concern B (Clinical Risk Management)



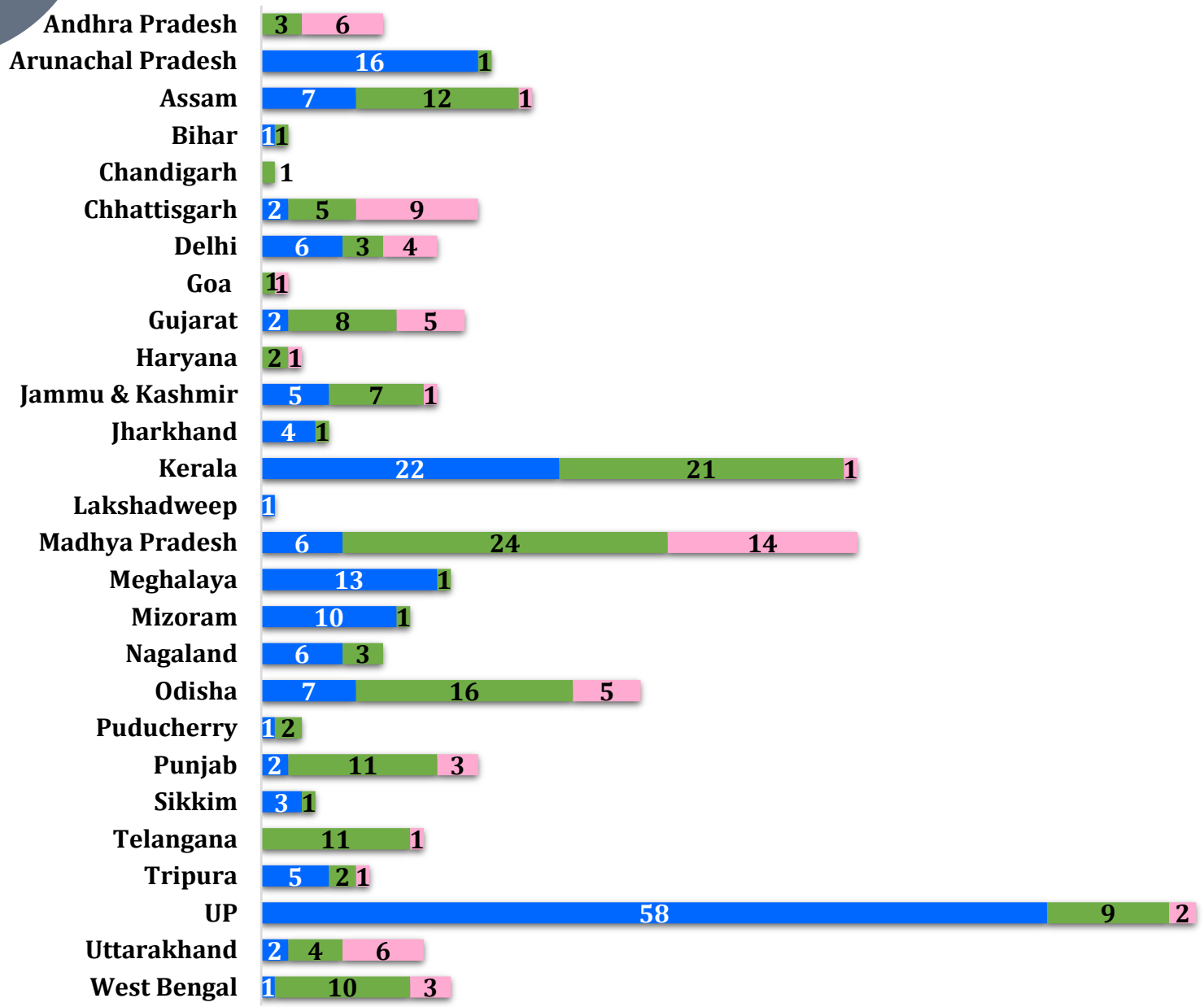
Scores of Area of Concern C (Safe Care Environment)

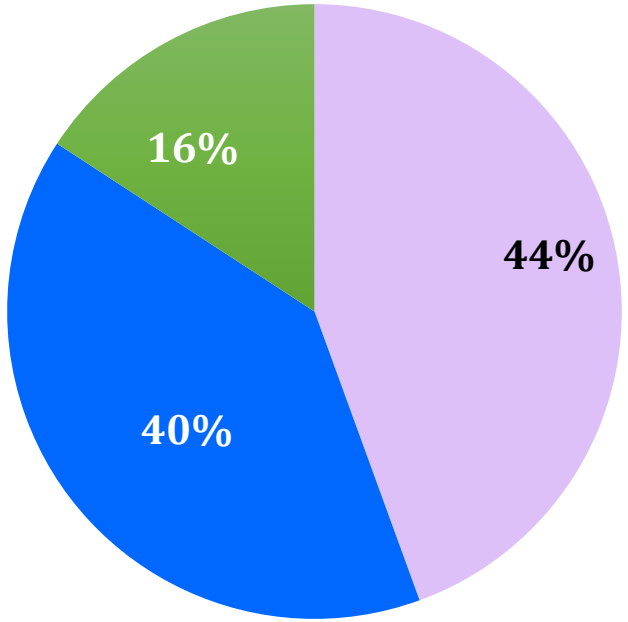


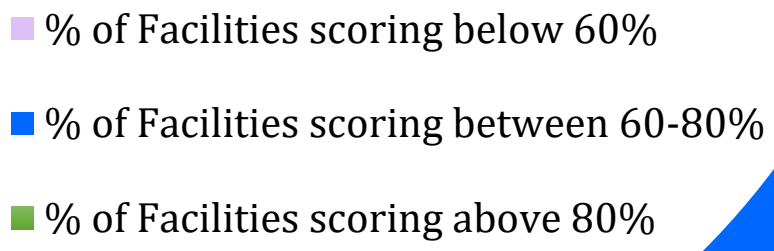
Scores of Area of Concern D (Patient Safety System)



Facilities as per SaQushal Scores



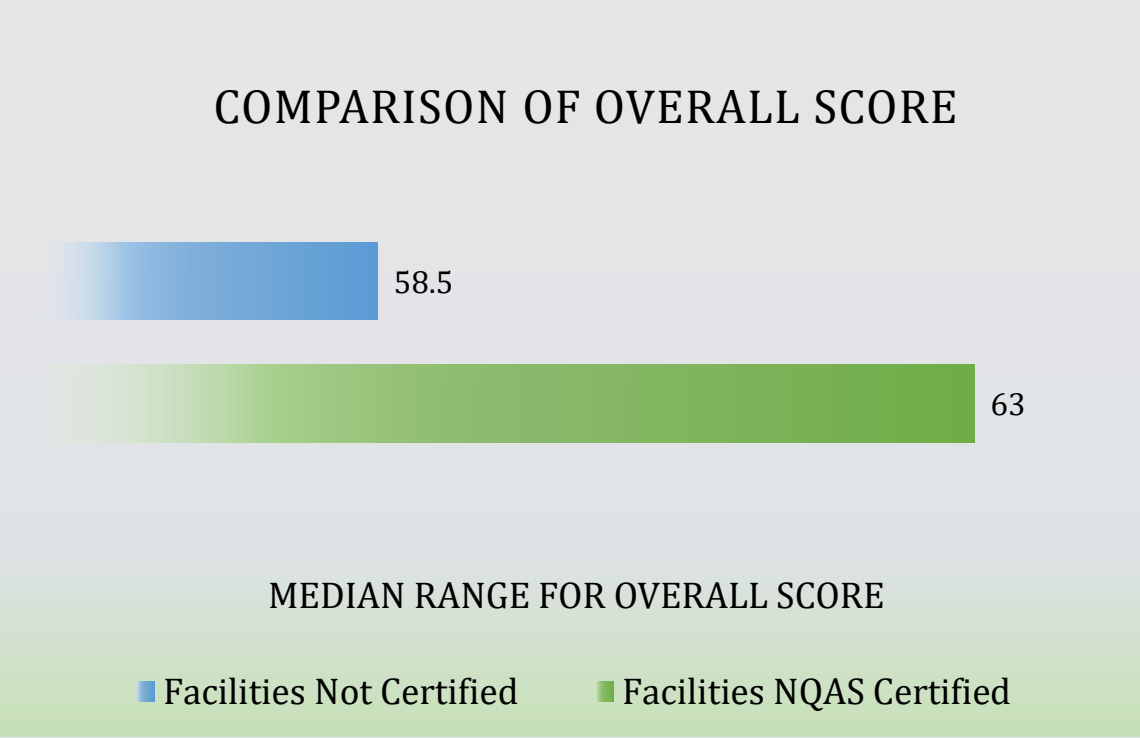


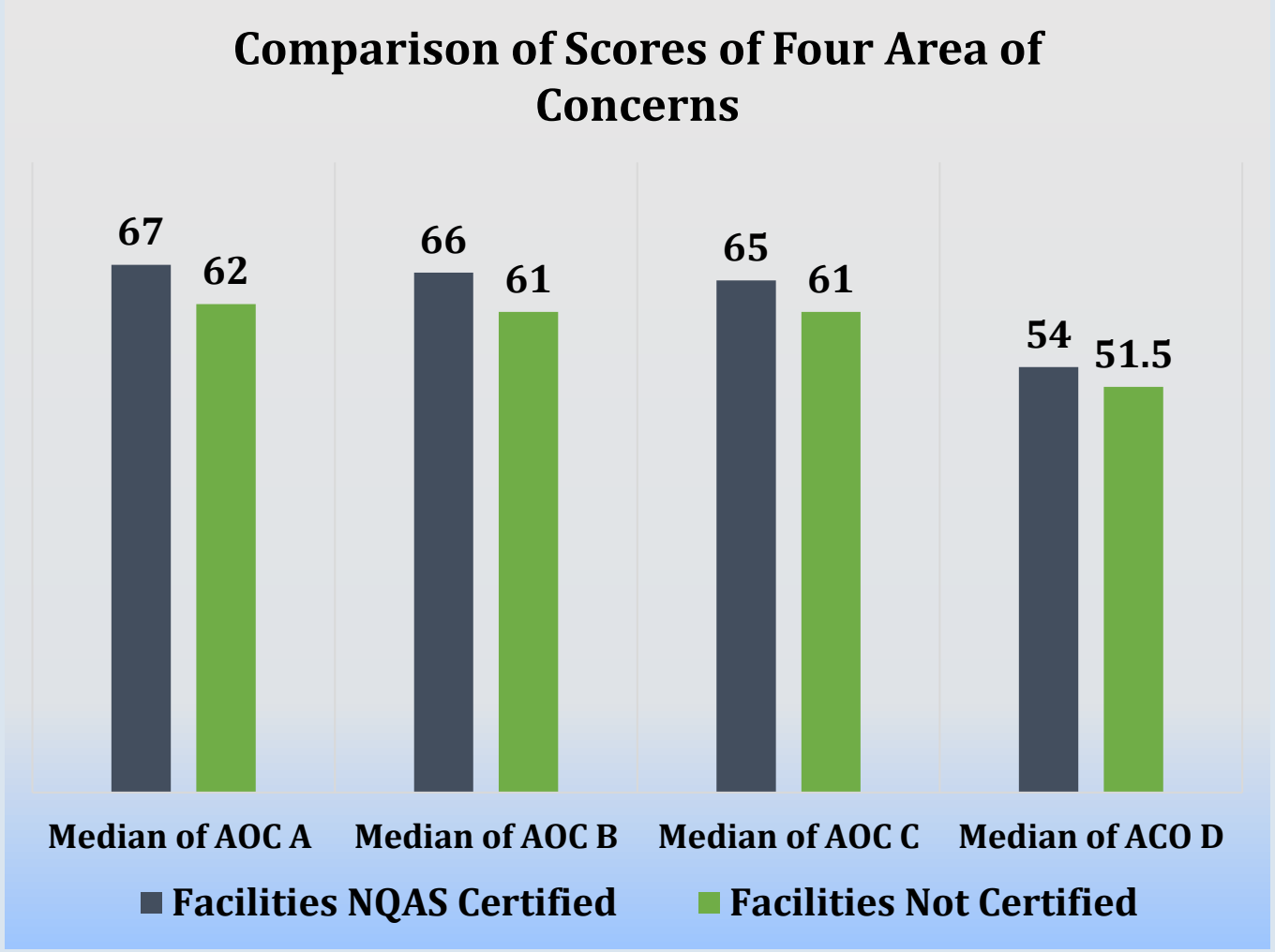


NQAS certified VS non-certified facilities

Total Assessed District Hospitals via SaQushal: 405

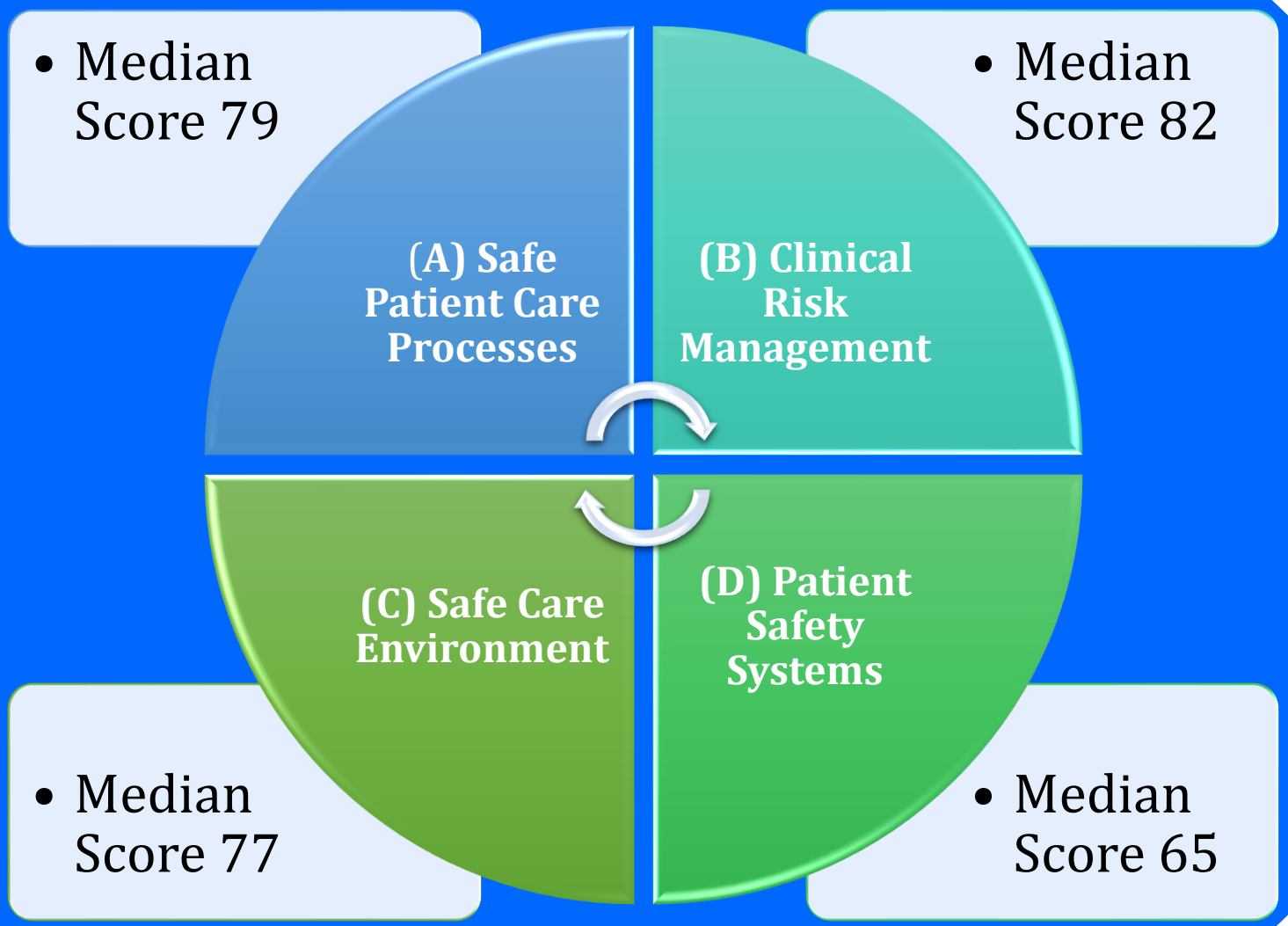
No. of Facilities NQAS Certified	No. Of Facilities Not Certified
101	304





Diagnostic errors

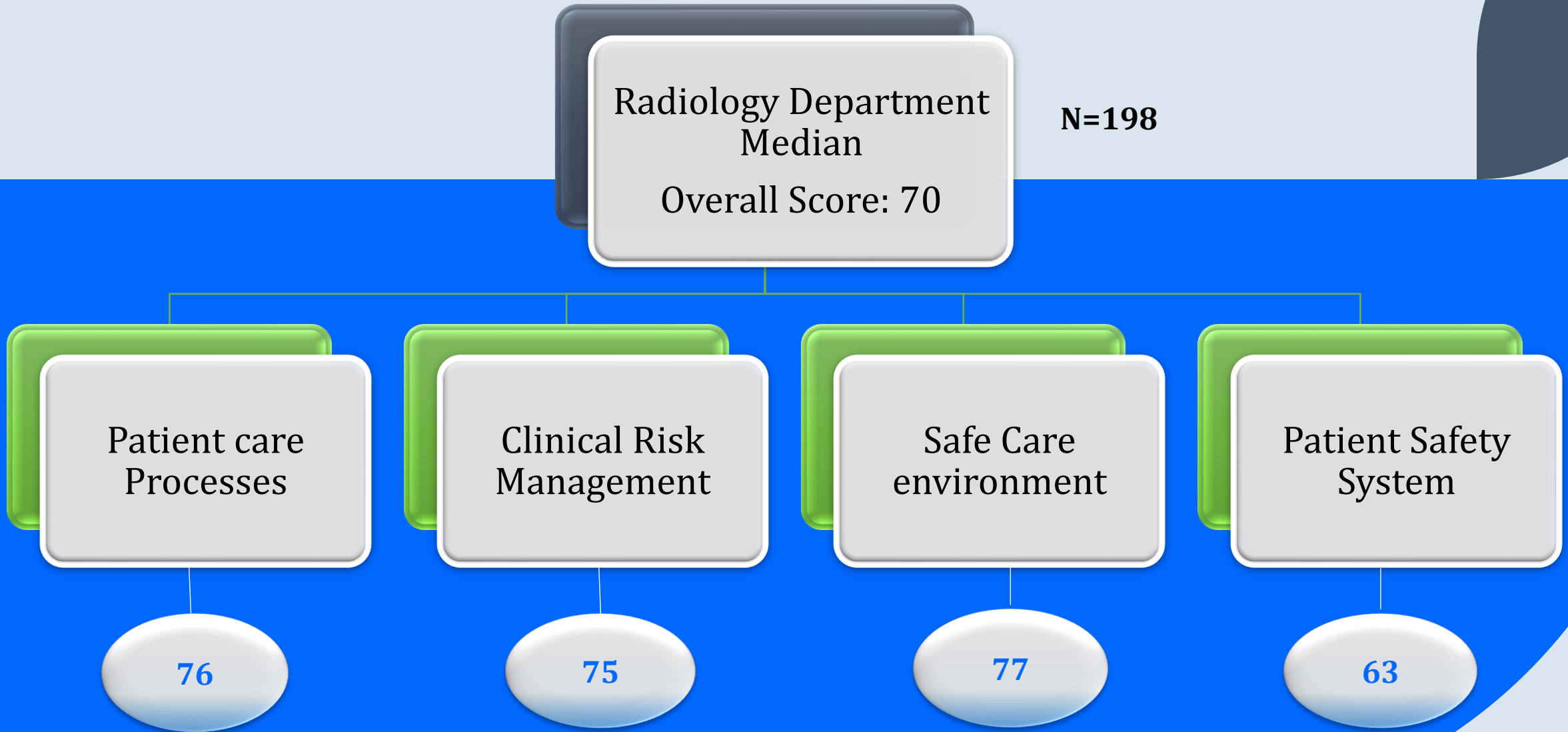
- **Delayed, wrong or missed diagnosis,** where there are missed opportunities to pursue or identify an accurate, timely diagnosis based on available information.
- **Contributing factors** include Cognitive and systematic factors
- Clinical training, experience, biases, fatigue, stress, communication, workload, teamwork issues.
- **Patient–practitioner encounters** such as History, examination, interpretation or results and follow-ups.



Overall Laboratory Median Score 74

N=198

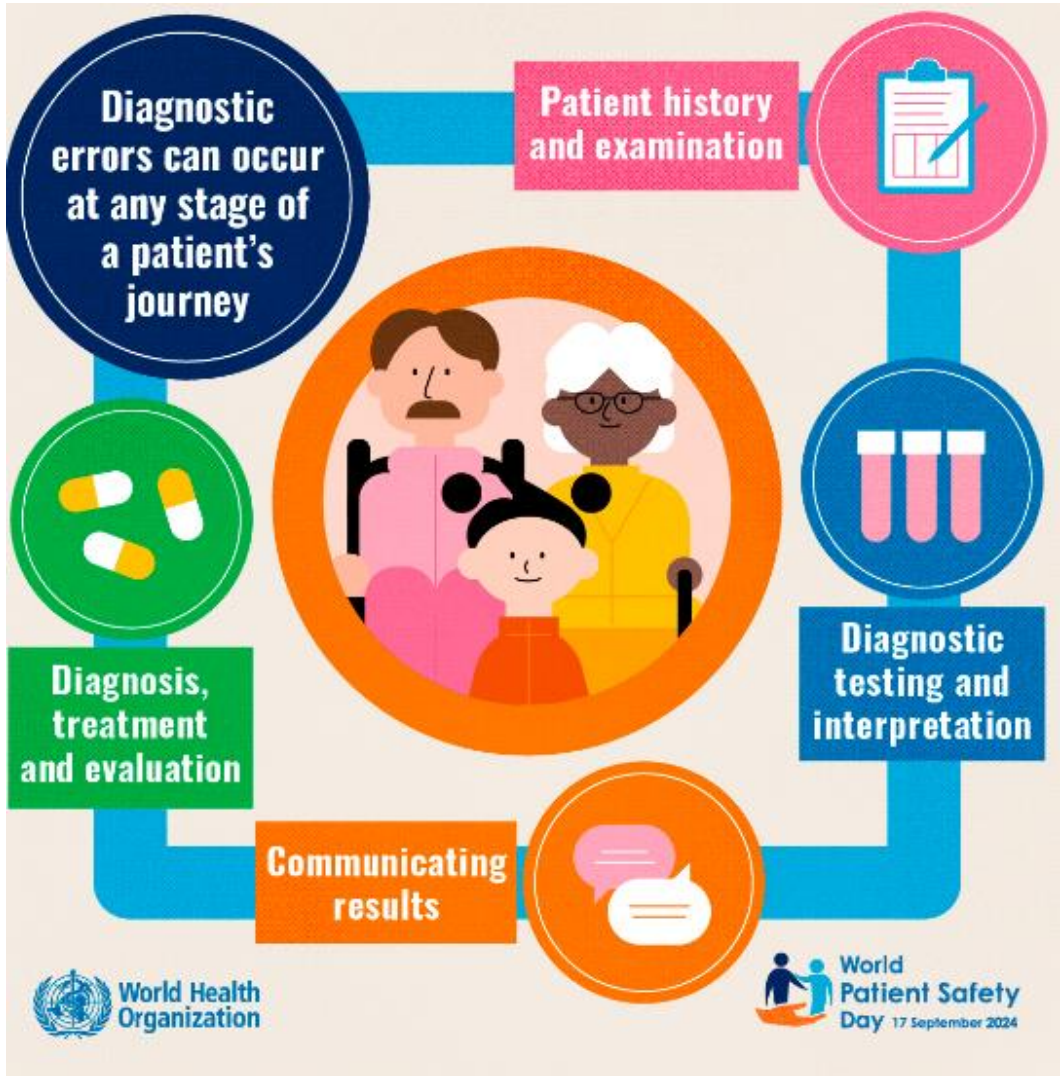
Radiology Score



Overall Score	**63**
Diagnostics Error Prevention	**70**
Ability at Point of Care (Multidisciplinary Teams, Competence-based tasks, training & education etc)	**56**
Communication at Transition of Care (Intramural communication, referral, discharge, follow-up, risk & hazards etc)	**60**

Conclusion and Way Forward

- Technique Improvement
- Education and technology-based interventions
- Personal change
- Improvement of communication teamwork
- Address cognitive bias
- Quality Improvement initiatives



Safety doesn't happen by accident; it requires discipline and diligence to recognise and mitigate every harm in HCFs.