सत्यमेव जयते
Ministry of Health & Family Welfare
Government of India

NATIONAL HEALTH MISSION
राष्ट्रीय स्वास्थ्य मिशन

World Patient Safety Day Report 2024

18th September 2024

National Health System Resource Center
Ministry of Health and Family Welfare

Introduction

The issue of patient safety is stark with estimates suggesting that as many as 1 in 10 patients in developed countries are harmed while receiving hospital care. The burden of unsafe care is disproportionally high in LMICs. Estimates show 134 million adverse events in LMIC hospitals every year, contributing to 2.6 million deaths. These alarming figures underscore the urgent need for robust safety measures across all healthcare settings.

Every step in the process of care-giving is associated with a certain degree of inherent unsafety. Patient Safety focuses on minimizing risks, errors, and harm to patients during the provision of healthcare services. It is a fundamental principle of healthcare and is now being recognized as a large and growing global public health challenge. By focusing on patient safety, healthcare systems can not only prevent harm but also improve the overall quality of care, leading to better health outcomes and increased trust in the healthcare system. In order to ensure quality of care and patient safety a coordinated effort across all levels of healthcare is required. It involves adherence to standards, ongoing education and training for healthcare providers, and active involvement of patients in their own care. By concentrating on these areas, healthcare organizations can ensure that they meet the needs of patients while minimizing the risk of harm.

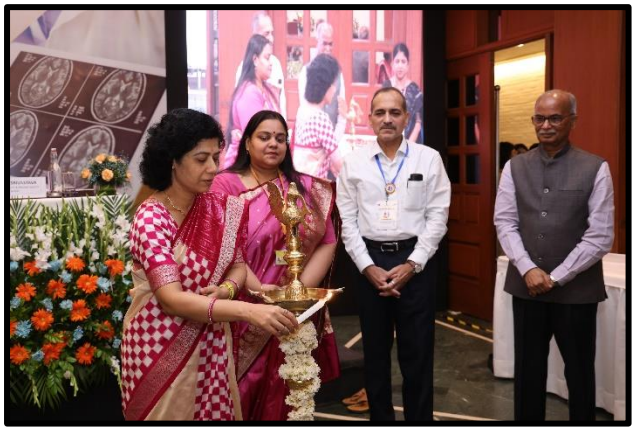
There is a worldwide shift towards patient-centered healthcare, where the needs, preferences, and values of patients are central to care delivery. Many countries have implemented shared decision-making models, empowering patients to be active participants in their own care.

The Seventy Second World Health Assembly (WHA), vide it's resolution WHA 72.6 in May 2019, brought attention to the issue of patient safety and endorsed the creation of an annual World Patient Safety Day, to be observed globally on 17 September. World Health Assembly (WHA) also called for the development of a global patient safety action plan. This plan was subsequently adopted by the Seventy-Fourth World Health Assembly in 2021, with the vision of achieving "a world in which no one is harmed in healthcare, and every patient receives safe and respectful care, every time, everywhere." Global Patient Safety Action Plan 2021–2030, provides a strategic direction for concrete actions to be taken by countries, partner organizations and health care facilities.

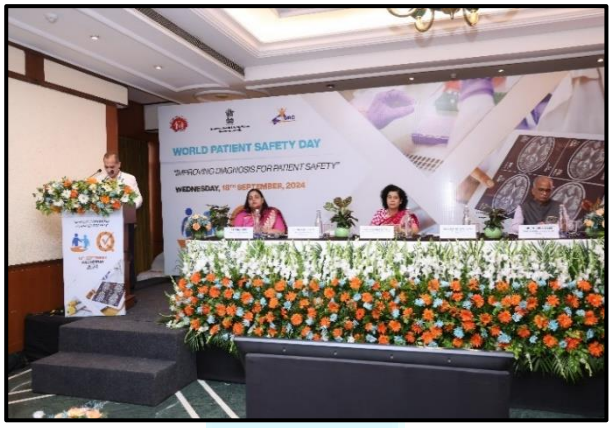
Initiatives of Government of India aligning with global efforts, has made significant strides in advancing patient safety as part of its broader commitment to achieving Universal Health Coverage (UHC). The country has undertaken numerous efforts at national and state levels to address diverse patient safety challenges, including unsafe injection practices, healthcare-associated infections, medication safety, and the growing threat of antimicrobial resistance. These efforts are complemented by the establishment of frameworks and standards that promote safe, effective, and patient-centered care.

Yearly celebration of **World Patient Safety Day** serves as a vital reminder of the need to prioritize patient safety within healthcare systems and highlights the pressing challenges and opportunities for improving the quality of care. The observance of this day aims to foster a culture of safety within healthcare organizations, where errors are minimized, patient care is continuously improved, and the voices of patients and families are heard and valued. The theme of **World Patient Safety Day 2024, "Improving Diagnosis for Patient Safety,"** with the slogan "**Get it right, Make it safe**," underscores the critical importance of accurate and timely diagnosis in ensuring patient safety. Diagnostic errors, which are often under recognized and inadequately

addressed, pose a significant risk to patient outcomes, contributing to delays in treatment, unnecessary procedures, and preventable harm. This year's theme highlights the need for systematic improvements in diagnostic processes to enhance the overall safety and quality of healthcare.



Lamp Lightening Ceremony - From left to Right - Smt. Aradhana Patnaik, Additional Secretary & Mission Director, National Health Mission, MOHFW, Dr Neha Garg, Director, NHM II, Maj. General (Prof.) Atul Kotwal, ED, NHSRC and Dr J N Srivastava, Advisor QPS, NHSRC.



From left to Right - Maj General (Prof.) Atul Kotwal, ED, NHSRC, on the dais, Dr Neha Garg, Director, NHM II, Smt. Aradhana Patnaik, Additional Secretary & Mission Director, National Health Mission, MOHFW and Dr J N Srivastava, Advisor QPS, NHSRC.

Inauguration and Welcome Address – World Patient Safety Day 2024

Dr J N Srivastava, Advisor QPS, NHSRC warmly welcomed Smt. Aradhana Patnaik, Additional Secretary & Mission Director, National Health Mission, MOHFW; Major General Atul Kotwal, SM, VSM Executive Director, NHSRC and Dr Neha Garg, Director, NHM II. He was grateful to Mr Harsh Mangla, Dr Saroj Kumar, Dr Hilde, Dr Anuradha Jain, and Air Commodore (Dr.) Rajan Chaudhary VSM, Advisor - HCT, NHSRC for enriching this event with their presence. He also extended welcome to representatives from 22 states and Union Territories, attendees from academic institutions, NGOs, development partners, and participants working in the field of patient safety. He provided a brief introduction of the national celebration of World Patient Safety Day, emphasising the theme "Improving diagnosis for patient safety". He noted that diagnostic errors account for 16% of the statistics of patient harm, which are overlooked by healthcare providers, urging a need for global awareness.

Dr. Srivastava expressed immense pride in stating that India is one of the countries that had a National patient safety implementation framework (NPSIF) much before the World Health Assembly passed the global resolution, and many components of this framework are already being implemented and incorporated in NQAS. He requested the support from all the states, development partners, and representatives from other organisations in rolling out the NQAS certification in all the public health facilities. Finally, he pointed out that celebration of World Patient Safety Day focussed on different themes each year. He emphasized that ensuring safety in diagnosis can wade off the chance of mistrust and help in reduction of out-of-pocket

expenditure (OOPE) in the country. He also cited the operationalisation of Integrated Public Healthcare labs (IPHL) under the PM-ABIM and NHM projects, which are growing in number but have yet to be integrated across all states.

Address by Maj. General (Prof.) Atul Kotwal, SM, VSM, Executive Director, NHSRC.

Maj. Gen. (Prof.) Atul Kotwal welcomed all the dignitaries and state representatives and asked them to extend their support in building trust with the patients of the entire community. He further stressed the point of monitoring and sustaining the NQAS-certified facilities with quality processes, inputs, and output indicators which is quite challenging yet rewarding.

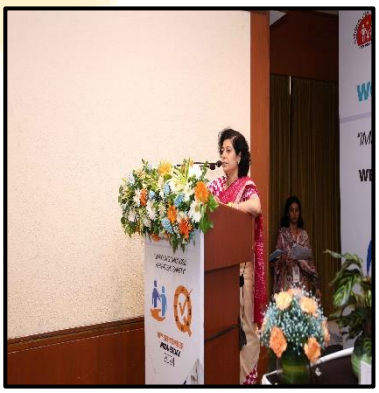
Maj. General (Prof.) Atul Kotwal, SM, VSM, Executive Director, NHSRC

He also highlighted the key achievements of the quality and patient safety division at NHSRC. It was noted that the team at the centre is working arduously with the all states and UTs in order to carry assessments of the district hospitals. The assessment intends to mark the gaps and accelerate the process of NQAS certification. He congratulated QPS Division at NHSRC for becoming WHO collaborating centre for implementing Patient Safety programs (WHOCC IND-173) and fostering collaboration with Clinical Research Organizations.

Government of India has put their foot forward in ensuring Patient Safety by creation of a IPHS tool in reference to SaQushal for self-assessment and quality improvement of all healthcare facilities. Executive Director also discussed about strengthening "Free Drugs and Diagnostics Service" initiatives of MoHFW as per the level of care. There should be movement of samples, investigation reports from the AAM-Sub Centre level to tertiary level hospitals, and from block level to district level, emphasising the ease of living and a sharp drop in out-of-pocket expenditure.

Address by Smt. Aradhana Patnaik, Additional Secretory and Mission Director, NHM, MOHFW, Government of India.

The Additional Secretary & Mission Director, MoHFW, emphasized the critical need for precision in patient care. She highlighted the significance of addressing avoidable errors, as doing so can help save valuable lives. She urged everyone to focus on this aspect, encouraging efforts to improve patient safety and save more lives. Government of India initiative of Distribution of Free drugs have resulted in reduction of out-of-pocket expenses from 69% to 42% though 40% of the out-of-pocket expenditure is still attributed to drugs and diagnostics. She Stated that all states should try to maintain 50-60% availability of the Essential Medicines, and the goal is to have 80% of the Essential Medicine List available in all facilities: sub-centres, PHCs, CHCs, SDHs, and DHs.

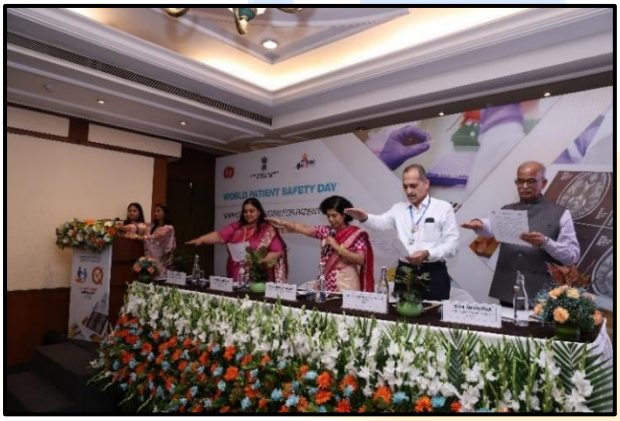


Smt. Aradhana Patnaik – Additional Secretary and Mission Director, NHM, MoHFW, GoI

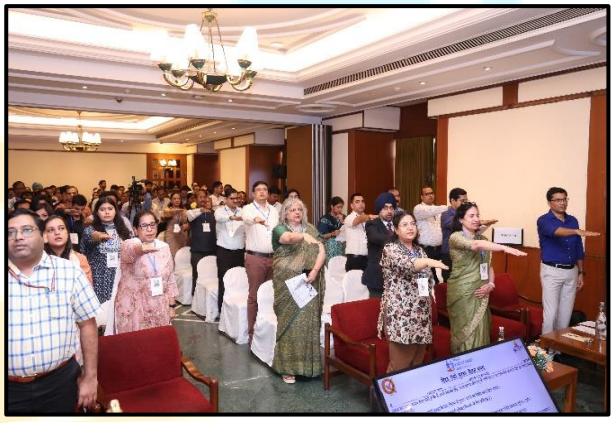
She emphasised the importance of NQAS certification as patient safety is a major part of the NQAS program. Recently, virtual certification of AAM-SC was started to accelerate the NQAS certification. She also talked about the progress of NQAS certification overtime from 10 facilities in 2015 to now approx. 14,000 facilities being certified with the support of the QPS team and guidance from the ministry. Ministry is committed to achieve the target of 50% of the healthcare facilities as NQAS certified by 2025 and 100% by December 2026. It is necessary to maintain and take follow-up of the facilities after the certification and increase the number of training or refresher courses for the assessors. She also highlighted the initiative of fund release for facilities linked to the progress made in NQAS certification and adherence to some basic standards of the IPHS 2022 guidelines. On 28th June 2024 a self-assessment tool for IPHS dashboard was launched by the Honourable Health Minister. This tool aids in finding out the gaps in infrastructure, human resources, drugs or diagnostics, service provision and governance, etc. More than 85,000 facilities have already done self-assessment, which is 42% of the achieved target.

Patient Safety Pledge 2024

Following inauguration Smt. Aradhana Patnaik, Additional Secretory and Mission Director, NHM, MOHFW, GOI administered Patient Safety Pledge. The Patient Safety Pledge 2024 highlights a commitment by healthcare professionals to enhance patient safety by undertaking actions to reduce errors in patient care, improve skills and knowledge related to safety, and actively engage patients and their families as partners in care. The pledge was administered first in Hindi and then in English to 150 participants present at the venue and 3000 professionals who had joined the national event online. Copies of the Pledge are attached as Annexure 2.



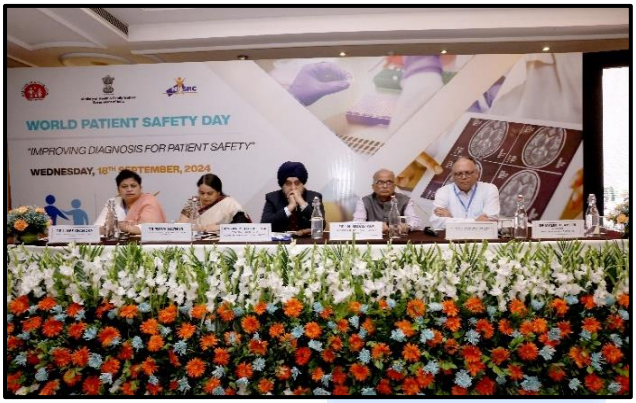
Administration of Patient Safety Pledge by Smt. Aradhana Patnaik, Additional Secretory and Mission Director, NHM, MOHFW, GOI



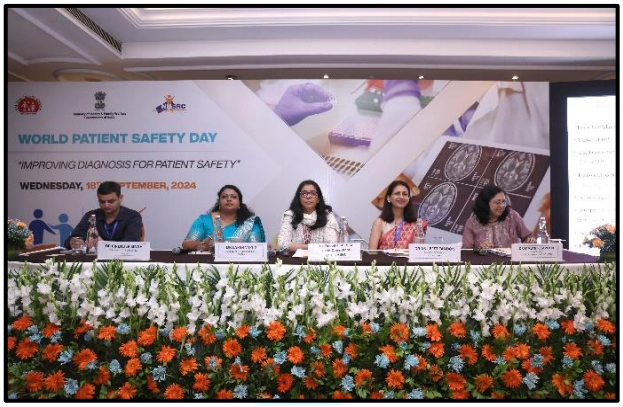
Uptake of Patient Safety Pledge by Participants present at Indian Habitat center, New Delhi

Technical Sessions

The Technical Sessions were conducted in two rounds by National level experts proficient in their respective fields. The experts spoke on various aspects of patient safety, aligning with this year's theme: 'Improve Diagnosis for Patient Safety.' They highlighted the need for accurate and timely diagnosis as a cornerstone for reducing patient harm and ensuring safer healthcare delivery.



Panelist for Technical session I



Panelist for Technical session II

Session I

Improving Diagnosis for Patient Safety – An Overview: Dr J N Srivastava, Advisor, QPS, NHSRC


Dr. JN Srivastava – Advisor QPS, NHSRC

- Dr. J.N Srivastava began the session by highlighting the importance of diagnostic safety. He discussed that diagnostic safety is the cornerstone of patient care. It is the foundation of effective treatment and equitable care for all and concerns all clinical disciplines and health programmes. It should be mentioned here that the 16% of preventable patient harm globally is related to Diagnostic errors, and despite this Diagnostic Safety is NOT prioritised".
- If we talk about the economic impact of diagnostic errors, OECD estimates diagnostic errors in chronic illness treatment represent about 5% of health expenditure in member countries.
- He clearly mentioned the challenges in providing diagnostic services regarding its underuse, overuse and misuse.
- He further defined preventable diagnostic harm (delayed diagnosis, wrong diagnosis and harm to workers) as an overlap between a missed opportunity due to health System issues (access & equity) and no missed opportunity.
- Advisor, QPS, NHSRC concluded his session by elaborating on diagnostic safety due to delayed, wrong, missed diagnosis and diagnosis not being communicated to the patients and regarding major challenges in improving diagnostic safety.

Session 2

Diagnostic Errors – The Next Frontier for Patient Safety: Air Commodore (Dr.) Ranjan Kumar Choudhury VSM, Advisor - HCT, NHSRC

Air commodore (Dr.) Ranjan kumar Choudhary VSM, Advisor-HCT, NHSRC.

- Dr. Chaudhary started his session by emphasizing on 9 moments of Patient Safety and regarding the burden of diagnostic errors. He stated that there is a lack of culture of reporting and recording of medical errors and that precise data is not available regarding diagnostic medical errors.
- He highlighted that Medical Device Adverse Events database under the National Materiovigilance Programme (MvPI) acts as repository of adverse events.
- He explained the common diagnostic errors such as failure to diagnose an unrelated disease, delayed diagnosis, failure to diagnose related disease, missed diagnosis and misdiagnosis. Diagnostic error can lead to Sentinel, Adverse or Near Miss Event.
- He discussed about reporting of medical device adverse events. Also, he mentioned about medical device adverse Event (MDAE) Reporting Form i.e. MvPIMDAE which is available on the IPC website, NCC-MvPI helpline numbers and mobile applications of Pharmacovigilance programme of India PvPI which are freely available on google play store.
- He further explained the factors contributing to diagnostic errors such as cognitive errors which is the most common error, flaws of system, process breakdown and lack of communication.
- He ended his session by suggesting potential interventions that can reduce burden of diagnostic errors such as training and capacity building, empowering patients by improving communication, strengthening health systems, robust referral and follow up mechanism at the primary healthcare settings, use of IT and EMR for recording all transactions- teleconsultations, tele-radiology, tele-pathology etc, improving access to diagnostics -EDL, Mini Diagnostic Hubs at Block CHC level and by encouraging culture of self-reporting of diagnostic errors, near miss event and adverse event.

Session 3

Key Performance Indicators for Labs – Dashboards for Improving Accuracy and Efficiency: Dr. Purva Mathur, Prof. Microbiology, JPN Apex Trauma Centre, AIIMS

- Dr. Mathur, started her session by defining Key Performance Indicators (KPIs). She mentioned regarding the attributes of a KPI.
- She explained the factors that affect the lab during Pre-Analytical, Analytical and Post Analytical phases.
- It was further emphasized the role of Key Performance Indicators (KPIs) in improving diagnostic efficiency.

- Dr. Mathur discussed regarding the Key Performance Indicators (KPIs) for Pre-Analytical phase such as syntax errors during registrations, no. of veni-puncture failures, no. of sample rejection etc, indicators for Analytical phase such as no of retest on patients, blood contamination rates, and Post Analytical phase such as TAT, no. of reporting errors etc.
- She concluded her session by sharing Key Performance Indicators (KPIs) that are being used at JPN Apex Trauma Centre, AIIMS Lab.
- Dr. Mathur gave details on how to use the data of KPI. She mentioned that :-

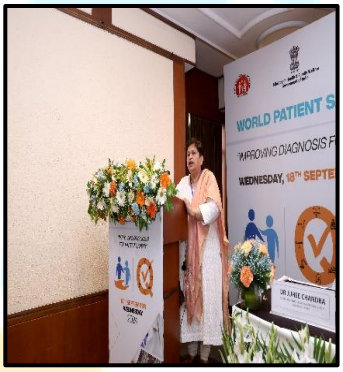
Dr. Purva Mathur Prof. Microbiology , JPN Apex Trauma

  - All or a selected few KPIs should be monitored monthly or as defined by the laboratory.
  - This monitoring can be represented in the form of Run Charts.
  - A specific and designated threshold should be set for these KPIs so that monthly analysis can guide decision-makers in improving areas where necessary.
  - Threshold definitions are an essential measure required for an adequate, informed and complete utilisation of KPIs.
  - The laboratories can set thresholds as per their convenience.
  - These thresholds need to be periodically reviewed and monitored.

Session 4

Laboratory Safety Audits – Improving Safety Practices and Occupational Safety: Dr. Juhee Chandra, Pathologist & QA Expert

- Dr. Juhee Chandra started her session by highlighting the importance of safety in medical laboratories. Safety in medical laboratories is for lab staff, for patients, attendants and visitors.
- She mentioned that lab safety audit is important for risk identification, regulatory compliance, improving safety culture and for resource optimization.
- While preparing for the Audit Schematically one Should first Identify the safety team, review previous audit reports, Prepare a checklist, communicate with Lab staff.
- She further explained on preparing for the audit by identifying a safety team, reviewing previous audit report, preparing a checklist, by communicating with a lab staff and by conducting lab safety training.
- She discussed regarding various dimensions of safety that has to be taken into consideration when safety of lab is taken into account a) Biosafety b) Chemical Safety c) Electrical Safety d) Mechanical Safety e) Fire Safety ensuring general safety, emergency protocols, availability of laboratory equipment's, chemical safety, electrical safety, mechanical safety, fire safety, provision of Bio Safety Laboratories (BSL), Biomedical Waste Management process.



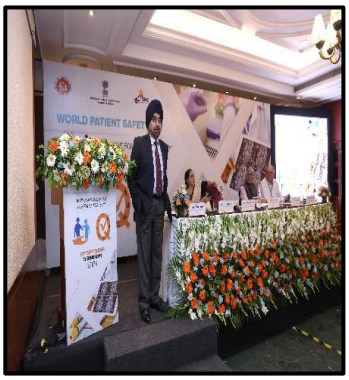
Dr. Juhee Chandra, Pathologist & QA Expert.

- She suggested practices for cleaning and disinfection and process for decontamination and disposal and concluded her session by discussing the roles and responsibilities of a Safety Officer.

Session 5

Clinical Audits for Enhancing Diagnostic Safety: Maj. Gen (Dr.) Jagtar Singh, VSM Director Academy of Hospital Administration

- Dr. Jagtar Singh started his session stating that 1 in 20 adults will experience a diagnostic error in an outpatient setting. He emphasized on importance of safety in diagnostic services.
- He explained the key features of clinical audit and steps for conducting an audit.
- He further added that the intent of audit such as for solving problems associated with process or outcome, monitoring process, workload, for reliability & validation and for monitoring adherence with best practices.
- He discussed regarding selection of clinical audit topics such as medication safety, infection control, patient satisfaction, adherence to clinical guidelines and patient safety incidents. He further discussed topics for enhancing diagnostic safety such as compliance to standards & SOPs, efficiency of diagnostic process, continuity of care and resource utilisation.
- He suggested levels of clinical audits to enhance diagnostic safety along with possible clinical audit outcomes in lab.
- The session was concluded by suggesting tips for conducting successful clinical audit.

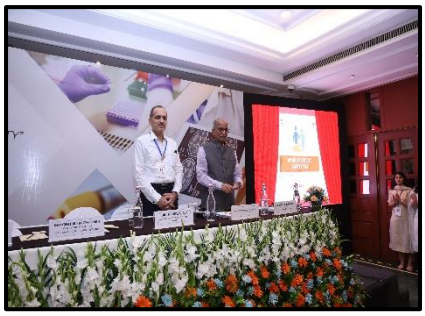


Maj Gen (Dr) Jagtar Singh, VSM Director Academy of Hospital Administration

Additional Activities

The National level Event also featured launch of a comprehensive **Coffee Table E-book** that captures a wide array of activities and initiatives undertaken at both the national and state levels in 2023. The E-book focuses on the theme "**Engaging Patients for Patient Safety**," emphasizing the pivotal role of patient involvement in enhancing healthcare safety standards.

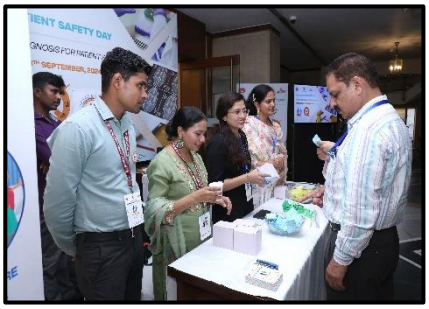
During the tea and lunch breaks, a dedicated quiz counter was set up to engage participants and test their knowledge on various aspects of patient safety. Participants were invited to answer questions covering a range of topics. To add an element of fun and excitement, spot prizes were awarded to participants who answered questions correctly and promptly.



Launch of Coffee Table E book

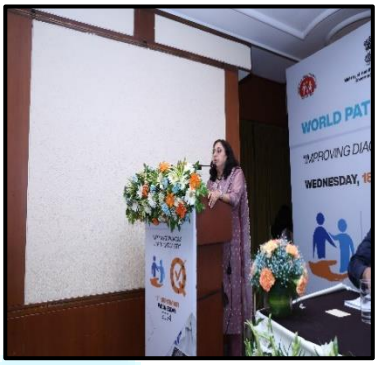
&

Quiz Counter



Session 6

Importance for EQAS participation for Public Health Facilities by – Dr Malini R Capoor, Prof. Microbiology, VMMC & SH



Dr. Malini R Capoor Prof. Microbiology, VMMC & SH

- Dr. Malini started her session by focussing on the fact that the Public health includes epidemiology, informatics, and surveillance prevention, and an effective laboratory is the central focal point.
- She mentioned the launch of National Quality Assurance Standards for IPHL by the NHSRC and shed light on the fact that the emerging and re-emerging of infectious diseases, the high prevalence of non-communicable diseases, and the resurgence of monkey pox are some major challenges in the public health system, and therefore we need effective healthcare solutions and efficient healthcare diagnosis and delivery mechanisms.
- She stated the need to have cost-effective laboratory systems to deliver rapid, reliable, and accurate test results for optimal impact on patient care and discussed the network of IPHL where the district is the epicentre. She briefly mentioned are the vision statement and key functions of the IPHL, which have a major focus on water quality and the development of point-of-care tests at basic public health levels.
- She also discussed the importance of lab report data, as 70% of clinical decisions are made based on lab results, as per the US study. She briefly explained integration of IPHL network within public health system followed by upward linkages of IPHL medical colleges at the state level and district level integrated labs.
- She further highlighted the need to have precision and accuracy for external quality assessment followed by description of the External Quality Assessment, which is a system for objectively checking the lab performance using an external agency or facility with further emphasis on EQA participation for all labs as a requirement by the ISO 15189:202 standard.
- She laid emphasis on the proficiency testing process where the PT samples are regularly analysed, evaluated, and subsequently corrective actions are taken according to PT reports so labs are prepared for outbreaks or epidemic situations and with the requirements of national health programs.
- She closed her presentation by stating the advantages of EQAS-certified IPHL that are evidence-based investigation and implementation of appropriate control surveillance, early warning of public health events, especially in cases of outbreaks and epidemic-prone diseases, introduction of new vaccines, and treatment and prevention policies and protocols at national and regional levels.

Session 7

Practices for improving Radiodiagnosis for Patient Safety by – Dr Anupreet Tandon, Radiologist & QA Expert

Dr. Anupreet Tandon, Radiologist and QA Expert

- Dr. Anupreet provided a concise overview of the workflow in a radiology department, starting from the request for imaging, scheduling, image acquisition, interpretation of images and data, reporting, and finally, follow-up care.
- She also touched on the fundamentals of radiology, discussing the harmful effects of radiation. She cited the case of Marie Curie, who passed away from aplastic anaemia caused by radiation exposure. She then described the layout planning of a radiology department, showing a diagram of an X-ray room where the bed is centrally positioned with the X-ray tube above it, maintaining a distance of 2 meters from the wall. Additionally, she discussed the importance of measuring the thickness of shielding materials.
- To enhance radiation safety, she suggested several measures, including the use of alternative imaging modalities, optimizing radiation doses, and applying the ALARA (As Low as Reasonably Achievable) principle. This principle involves reducing exposure time, increasing the distance from the radiation source, and using protective shielding such as lead aprons, collars, mobile lead shields, and barriers. She also highlighted the use of lightweight aprons made from bismuth and emphasized the mandatory use of TLD (thermo-luminescent dosimeter) badges.
- In conclusion, she stressed the importance of quality assurance practices, such as regular equipment checks, employing safety features like automatic exposure control, ongoing staff training and education, and annual maintenance and calibration of machines.

Session 8

Analysis of SaQushal Self-Assessment Scores – Learning and Way Forward by – Dr Deepika Sharma, Lead Consultant, QPS, NHSRC

Dr. Deepika Sharma, Lead Consultant, QPS, NHSRC

- Dr. Deepika precisely highlighted the Self Assessment tool *SaQushal* launched nationwide in 2022 to assess District Hospitals across States and UTs. It was launched with an aim to improve quality in public health facilities, with a primary focus on secondary care institutions like district hospitals.
- Dr. Sharma stated that SaQushal assessments are conducted bi-annually, with scores shared at both the national and state levels. Data analysed till Dt. 16.09.2024 noted a significant increase of 22.1% in SaQushal assessments across district hospitals, increasing from assessment of 237 facilities to 405 over a one-year period.
- Comparative Analysis depicted that 8 states have conducted assessment in 100% of its facilities whereas 12 states have conducted assessments in 70-99% of their hospitals. She

pointed out that in states such as Bihar two district hospitals were assessed whereas Uttar Pradesh conducted assessment in 69 facilities the highest in 2023-24.

- Further analysis indicated that if we have to categorize facilities on the basis of SaQushal scores then only 16% of district hospitals (out of 405) scored above 80%, while 44% scored below 60% and scores of 40% of facilities fell between 60-80%.
- Comparisons between NQAS (National Quality Assurance Standards) certified and non-NQAS certified facilities revealed that NQAS-certified hospitals performed better across all Areas of Concern.
- Scores of Radiology Department and Lab Department were analysed to state that the overall median score was 70 and 74 respectively.
- At the end recommendations were given regarding several measures to improve diagnostic accuracy and patient safety, including the enhancement of diagnostic techniques, standardization of procedures, continuous education and capacity-building through simulation models, and fostering better decision-making and skill-building among professionals.

Session 9

Implementing SaQushal- Improving Patient Safety Practices in Healthcare by - Dr. Birender Singh, State Quality Nodal Officer, Gujarat.

- Dr. Birender started his presentation by briefing about the activities undertaken by the state including orientation of District Hospitals and Medical Colleges on SaQushal in April 2023 followed by implementation of tool.
- Gujarat has done assessments in 43 hospitals in which 17, 16, 10 assessments were done in SDHs, Medical Colleges and DHs respectively and scores ranged from 36% to 97%.
- Major observations were showcased according to each Area of concern.
    1) Patient Care Process - lack of hygiene practices among workers was observed and safe patient handling in facilities needs focus
    2) Clinical Risk Management- Mental & palliative healthcare services at DH Level needs more attention and shortage of specialist doctors & staff nurses, hired on contractual basis compromising quality of care
    3) Safe Care Environment- More space & infrastructural issues, structural safety need more focus, focus on SBCC regarding WASH practices
    4) Patient Safety System- Increased need of capacity building & training session for teams as well as availability of multidisciplinary teams in MCH level.
- The state of Gujarat through implementation of SaQushal tool has also listed some of the good practices that are automation in testing and recording systems in DH & MCH, functional Obstetric Intensive Care Units (OICUs) attached to labor rooms in MCH,

Dr. Birender Singh, State Quality Nodal Officer, Gujarat

availability of pre diagnostic screening and testing facilities, specialized units like Midwifery-Led Care Units (MLCUs) for fitness & nutritional supplements to ANC and PNC mothers.

- He closed his presentation by suggesting some measures that would be taken up by the state such as reassessment of facilities scoring below 70%, increased focus on physical safety and infrastructure with periodic audits in consultation with PIU, improvement in hygiene and WASH practices in facilities to be focused upon.

Session 10

Ensuring Safety in Palliative care at Home by Dr. Lakshmi G.G. State Quality Nodal Officer, Kerala

Dr Lakshmi G.G. State Quality Nodal Officer, Kerala

- She started by highlighting the emergence of non-communicable diseases which causes more misery to the patient. She pointed out that Kerala is experiencing a demographic shift, with a growing number of elderly individuals highlighting the urgent need for palliative care to address the increasing demands of this age group.
- She talked about the comprehensive elderly care and ARIKE community engagement strategy. Under the Palliative Care Program activities like care at AAM-SC level, LSGD level home care, delivery of medicines are performed. ARIKE community engagement strategy focuses on involvement of school and college level volunteers. She further mentioned the state palliative action plan where taluk hospitals act as First Referral Units for bedbound and home bound patients.
- Last year Kerala celebrated the patient safety day by conducting online sessions with palliative care providers and the community-based nurses in order to improve the awareness of different aspects of palliative care.
- State has started Quality & Patient Safety Initiative -2024 under which Palliative Care Quality Assurance Standards were created. The framework was developed indigenously by Palliative care team of the state and stressed on the psychosocial support in which Palliative Care Units were assessed.
- She focussed that training on palliative care principles and safety protocols is crucial for ensuring high-quality, compassionate care. It is required that there is strengthening of infrastructure, such as developing specialized palliative care units and improving access to essential medications.

Valedictory & Vote of Thanks

Maj Gen (Prof) Atul Kotwal, VSM, Executive Director, NHSRC thanked all the speakers for the wonderful sessions. He mentioned that over the years we have become very defensive in our practice as many times clinicians want tests to be done first and then examine the patients.

He mentioned that there is a huge misuse of diagnostics and that an overall approach of quality should be to conduct appropriate test at appropriate time for right treatment and diagnosis.

He explained that misuse of diagnostics, increases out-of-pocket expenditure and it's time to move outside from standard treatment guidelines towards standard treatment workflows and artificial intelligence (AI). It is required that we integrate clinical decision support system (CDSS) in health systems, have provision to report and identify systematic, random & negligent errors and hence undertake corrective and preventive actions for the same.

Way forward, he suggested to integrate all portal and apps, link dashboards with HMIS in order to utilize the skills and expertise to treat individuals at the right time. He congratulated the QPS team and State Quality teams for continuously improving the quality of healthcare facilities by traversing the gaps, providing support, and getting certifications done.

Annexure 1

World Patient Safety Day Event
Date – 18th September 2024
Venue: Silver Oak Hall, India Habitat Centre, New Delhi
Agenda

Time	Topic	Resource Person
9.30 AM – 10.00 AM	Registration	QPS Team
10 AM – 10.10 AM	**Welcome and Lamp Lighting**	
10.10 AM – 10.20 AM	Opening Remarks & Objectives	Dr. J.N. Srivastava, Advisor – QPS, NHSRC
10.20 AM – 10.30 AM	Address by Guest of Honour	Maj Gen (Prof) Atul Kotwal, SM,VSM ED, NHSRC
10.30 AM – 10.40 AM	Address by Guest of Honour	Shri Saurabh Jain Joint Secretary (Policy), MOH&FW
10.40 AM – 11.00 AM	Address by Chief Guest	Smt Aradhana Patnaik AS & MD, MOH&FW
11.00 AM –11.10 AM	Patient safety pledge “Primum non nocere-First Do No Harm" administered by Chief Guest	
11. 10 AM – 11.45 AM	**Group Photograph followed by Tea Break**	
Session I - Technical Seminar on WPSD Theme – Improving Diagnosis for Patient Safety		
11.45 AM – 12.00 PM	Improving Diagnosis for Patient Safety – An Overview	Dr. J.N. Srivastava, Advisor – QPS, NHSRC
12.00 PM – 12.20 PM	Diagnostic Errors – The Next Frontier for Patient Safety	Air Commodore (Dr.) Ranjan Kumar Choudhury VSM, Advisor - HCT, NHSRC
12.20 PM – 12.40 PM	Importance of EQAS Participation for Public Health Facilities	Dr. Malini R Capoor, Prof. Microbiology, VMMC & SH
12.40 PM – 1.00 PM	Key Performance Indicators for Labs – Dashboards for Improving Accuracy and Efficiency	Dr. Purva Mathur, Prof. Microbiology, JPN Apex Trauma Centre, AIIMS
1.00 PM– 1.20 PM	Laboratory Safety Audits – Improving Safety Practices and Occupational Safety	Dr.Juhee Chandra. Pathologist & QA Expert
1.20 PM – 1.40 PM	Clinical Audits for Enhancing Diagnostic Safety	Maj Gen (Dr) Jagtar Singh, VSM Director Academy of Hospital Administration
1.40 PM – 2.40 PM	**Lunch**	
Session II – Updates on SaQushal Implementation and Best Practices		
2.40 PM – 2.55 PM	Practices for improving Radiodiagnosis for Patient Safety	Dr. Anupreet Tandon, Radiologist & QA Expert
2.55 PM – 3.15 PM	Analysis of SaQushal Self-Assessment Scores – Learnings & Way Forward	Dr. Deepika Sharma. Lead Consultant, QPS, NHSRC
3.15 PM – 3.30 PM	“Implementing SaQushal-Improving Patient Safety Practices in Healthcare”	Dr. Birendra Singh, State Quality Nodal Officer, Gujarat
3.30 PM – 3.45 PM	“Ensuring Safety in Palliative Care at Home”	Dr. Lakshmi G.G. State Quality Nodal Officer, Kerala
3.45 PM – 4.00 PM	Valedictory & Vote of Thanks	
4.00 PM Onwards	Tea	

Annexure 2

Patient Safety pledge on occasion of World Patient Safety Day

I, _____[Name], currently working as---

- ---------- (Please mention your designation)

in ---------- (Name of your organization and place) **here by pledge to undertake all actions for promotion of Patient Safety in my health facility, community and country.**

Including the actions for improving diagnosis for patient safety. I commit to dedicate myself to make health care safer by supporting, but not limited to, following actions, namely:

1. Identification and implementation of the ways to reduce errors in patient care
2. Improving our skills and knowledge on all related subjects pertaining to patient safety
3. Actively engaging and empowering patients and families as partners in improving their care.
4. Raising public awareness about patient safety.
5. Nurturing, supporting and promoting transparency in care through team work.
6. Learning from errors for safeguarding interest of patients.
7. Supporting my professional colleagues in their endeavour of promotion of cause of patient safety.
8. Leverage available technology, tool and tests to reach a diagnosis.

विश्व रोगी सुरक्षा दिवस शपथ

मैं .....(आपका नाम) ..... (आपका पद का नाम) .....(आपकी संस्था का नाम) शपथ लेता/लेती हूं कि मैं अपने स्वास्थ्य केंद्र, अपने समाज और राष्ट्र में "रोगी सुरक्षा" को प्रोत्साहित करने के लिए हर संभव प्रयास करूंगा/करूंगी।

जिस में उपचार के दौरान "रोगी सुरक्षा के लिए निदान में सुधार" करने पर विशेष ध्यान दिया जाएगा।

मैं स्वास्थ्य सेवाओं को सुरक्षित बनाने हेतु महत्वपूर्ण भूमिका निभाने के लिए प्रतिबद्ध हूं।

जिसके लिए मैं निम्न प्रयास करूंगा/करूंगी -

1- रोगी के उपचार के समय होने वाली कमियों की पहचान करके उन्हें पूर्ण रूप से समाप्त करने हेतु प्रयासरत रहुंगा / रहुंगी।
2- रोगी सुरक्षा से संबंधित सभी विषयों पर स्वयं के ज्ञान को बढ़ाते हुए, अपने कार्य कौशल में सुधार लाउंगा/लाउंगी।
3- चिकित्सीय उपचार में सुधार के लिए रोगियों और उनके परिवार के सदस्यों को सक्रिय रुप से सशक्त और भागीदार बनाऊंगा/ बनाऊंगी।
4- रोगी सुरक्षा के बारे में सामूहिक जागरुकता बढ़ाऊंगा/ बढ़ाऊंगी।
5- सामूहिक सहयोग के माध्यम से स्वास्थ सेवाओं में पारदर्शिता का समर्थन एवं प्रचार करूंगा / करूंगी।
6- स्वास्थ्य सेवाऐ प्रदान करने में हुई त्रुटियों से शिक्षा ग्रहण करके स्वयं में सुधार लाउंगा/लाउंगी।
7- रोगी सुरक्षा को बढ़ावा देने के लिए अपने सहयोगियों द्वारा किये गए प्रयासो का समर्थन करूंगा / करूंगी।
8- रोगी निदान के लिए उपलब्ध तकनीक, साधन तथा परीक्षण का उत्तोलन करूंगा/करूंगी।