



WORLD PATIENT SAFETY DAY 2026

Safe Transitions of Care in NCDs

Never drop the baton: keeping information, medicines and follow-up moving with the patient

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World Patient Safety Day 2026: safe care for noncommunicable diseases

Slogan: “Safe care for life!” — no one should be harmed while receiving care for an NCD.

74%

of deaths worldwide are from NCDs (WHO, 2026).

Billions affected

Cardiovascular disease, cancer, diabetes, chronic respiratory disease — lifelong care, lifelong handovers.

Our focus today

The transitions inside that care - referral, admission, discharge, follow-up.

Source: World Health Organization, World Patient Safety Day 2026 — “Safe care for noncommunicable diseases”.

THE MAGNITUDE

India carries the NCD load — and every patient crosses many transitions

68%

of all deaths in India
are from NCDs.

6.3 million

NCD deaths in India
every year.

24%

risk of dying early
(30–70) from an NCD.

What the evidence shows about the handover itself

Unintentional medication discrepancies at care transitions are common and drive avoidable post-discharge emergency visits (BMC Geriatrics, 2024).

A substantial share of 30-day readmissions is medication-related — and much of it is preventable (Frontiers in Pharmacology, 2021).

Heart-failure readmission and mortality rates remain high worldwide, with wide variation between systems (J Am Coll Cardiol, 2023).

SECTION 01

Why transitions matter

Care moves between people and places every day — the information has to move with it.

Care moves. Information must move with it.



THE JOURNEY

Six settings, one patient

Home, clinic, emergency, ward, specialist and back again. A person with diabetes, hypertension or COPD may cross all six in a single month.

THE RISK

Risk sits in the gaps

Harm rarely happens inside a good consultation. It happens between them — when medicines, results and plans do not travel with the patient.

THE STAKES

NCDs are lifelong

Chronic care is continuous by design. Every gap compounds: a missed titration today becomes an admission next quarter.



TRANSITION POINTS

A seemingly simple transition can therefore fail at several points:

- **Hospital → home:** medicines changed in hospital are not clearly explained.
- **Specialist → primary care:** monitoring responsibilities are not communicated.
- **Emergency department → regular clinician:** temporary treatment becomes permanent unintentionally.
- **One specialist → another:** medicines are added without reviewing the complete treatment plan.
- **Laboratory → patient/clinician:** abnormal results are generated but not acted upon.

**The danger is often not one dramatic error.
It is a series of small gaps that line up.**

NCD care is similar: each referral, transfer and follow-up is a connection that must work.



High-Risk NCD Transitions

The road may be safe, but high-risk stretches need slower speed, more signs and closer monitoring.



Need extra vigilance

-  Heart failure
-  Stroke
-  Diabetes
-  Anticoagulation
-  Cancer
-  CKD
-  COPD
-  Multimorbidity
-  Polypharmacy



High-risk NCD transitions need clear plans, careful follow-up and early recognition of problems.



SECTION 02

Where transitions fail

Messages change, tests stay pending, and nobody is named as the owner.

Where transitions fail

Medication changes

Started, stopped or dose-changed in hospital - never reconciled at home.

Pending tests

Results return after discharge and no one is named to act on them.

Unclear responsibility

Everyone assumes someone else owns the next step.

Incomplete discharge info

Summary arrives late, or without the reason for each change.

Duplication

The same test repeated because the earlier one was invisible.

Missed monitoring

HbA1c, BP, renal function and retinal checks quietly slip.

Messages change during handovers

Every handover can shift the message a little. By the final listener, "**hold metformin for the scan**" has become "**stop metformin**".



What a safe instruction contains



Vague: "Sort out his sugars."

Specific: "Insulin 10 units at 8 pm; fasting glucose Thursday; Dr. Rao reviews the result."

Name the thing

Drug, dose, route, timing — never "continue the same treatment".

Name the person and the deadline

Who does it, by when — never "someone will follow up".

Confirm it was received

Ask the receiver to read it back, and write it where the next team will look.

Vague instructions get you effort, not accuracy. Specify the what, the who and the by-when - then confirm it was heard.

Pending tests

Every test needs an owner and an action: ordered → resulted → reviewed → acted upon → communicated.



WHO's 2026 patient-safety messages specifically encourage people living with NCDs to follow up their test results and to remain alert during referrals, handovers and discharge.

Make responsibility explicit

“Statements such as follow up with physician or review later are often unsafe.”

- A better handover states: **Who? What? When?**
 - **Primary care physician:** check creatinine and potassium within 7 days.
 - **Cardiology:** review heart-failure medicines in 4 weeks.
 - **Patient:** monitor daily weight and seek help for rapid weight gain or worsening breathlessness.



SECTION 03

Why they fail: system gaps

Transition failures come from aligned process gaps, not one careless person.

Systems Approach to Medication Errors



Domino Effect

*Safer
Medication
Safer People*

Small
failures
can lead to
big outcomes.

Harm often results from several small failures lining up
rather than one careless person.

One prevention
can stop the chain.



Break one link and the event may be prevented.

COOKING FROM A RECIPE

A checklist is not distrust
of skill — it is what lets
skill work under pressure.

Good
Food
Brighter
Days
♡

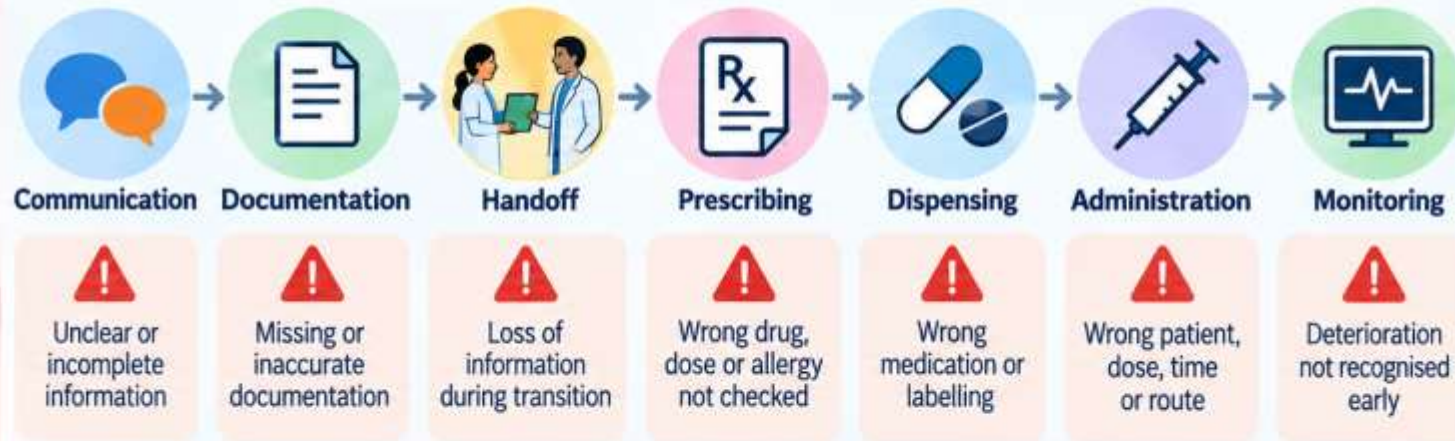


Checklists support consistency, safety and performance
when the stakes are high.

Blame **hides** real causes: a chain of system gaps

Real safety comes from understanding how small system gaps lead to errors.

SAFETY LOOKS AT THE WHOLE PROCESS



Study the process, not the person. | Better systems. Safer patients.

Digital enablers: make the safe way the easy way

Structured discharge summary

A template with mandatory fields: what changed, why, stop dates, pending tests, named owner.

Shared records: ABDM / ABHA

Link every episode to the patient's ABHA so the next clinician sees the same history.

E-prescriptions

Legible, coded medicine lists that kill look-alike errors and make reconciliation possible.

SMS / IVR reminders and recall

Appointment and refill reminders in the local language, plus an active call-back list for the patients who do not turn up.

Results tracking with a named owner

A pending-results dashboard that escalates until someone acknowledges and acts — no result closes itself.

The rails already exist: ABDM reports over 97 crore ABHA accounts and more than 119 crore linked health records across 5.7 lakh verified facilities (NHA, September 2026). The gap is use at the point of handover, not technology.

Right
information.
Brighter
tomorrows.

A Simple SAFE Transition Framework

FOUR KEY STEPS. A SAFER TOMORROW.



S



Summarize the clinical story

Diagnosis, important events, procedures, complications and current status.

A



Align the medicines

Reconcile, explain changes, identify high-risk medicines and monitoring.

F



Fix the follow-up

Specify appointments, pending results, investigations and responsible clinician.

E



Engage and empower the patient

Explain warning signs, self-care, medicines, contact points and when to seek urgent help.



SAFE transitions improve continuity, clarity and patient safety.



Safer care.
Healthier tomorrows.

SECTION 04

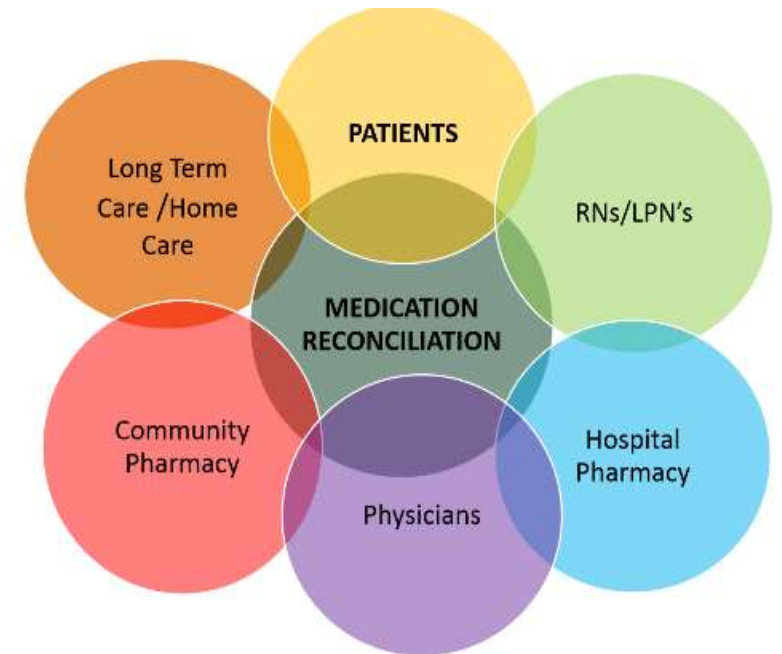
What good looks like

Reconcile the medicines, check understanding,
hand over the record, name the owner.

RECONCILIATION

Medication reconciliation: the single highest-yield act

- 1 Collect**
Build the best possible medication history - packets, pharmacy records, the family's list, not just the file.
- 2 Compare**
Line up what they were taking against what is prescribed now. Flag every difference.
- 3 Resolve & communicate**
Decide intentionally, record the reason, and tell the patient and the next clinician.



Admission is the easy half - the exit plan is where patients get trapped.

The discharge conversation: check understanding, not attendance

- Discharge is a clinical intervention, not paperwork — plan it from day one of admission.
- Send home a written plan in the patient's language: updated medicines, warning signs, who to call, next appointment.
- Teach-back is the check: "Tell me how you'll take the insulin tomorrow morning." Re-teach until they can say it back.
- Hand the plan to whoever actually manages the medicines at home, not only the patient.



Spoken or printed is not the same as understood.

Discharge at 9 pm on a Friday, to a patient who has just been told a diagnosis, is a conversation nobody remembers.

The handover record: what must travel with the patient

MEDICINES

Changed, stopped, continued

Each change with its reason and its stop date. Not a reprinted list.

RESULTS

Pending and owned

Every test still in flight, with a named person responsible for acting on it.

PLAN

Targets and next steps

BP, HbA1c or symptom targets, titration plan, and what to do if targets are missed.

CONTACT

A name, not a department

Who to call, when, and what counts as urgent enough to call at night.

Information
moves with
the patient,
NOT behind
the patient

ARIADNE'S THREAD

Theseus could face the labyrinth because someone made sure he could find the way back out.

CONTINUITY
GUIDANCE
CLARITY
BETTER CARE

SAFETY



GOOD
INFORMATION
GUIDES
SAFER CARE

A good handover record is that thread.

FROM COMPLEXITY TO SAFETY



Follow-up and ownership

Cricket fielding

If two fielders both think the other will catch the ball, it drops.



Healthcare takeaway

- Who**
Identify who is responsible.
- What**
Be clear about what follow-up is needed.
- When**
Agree when it should happen.

Follow-up responsibility should be explicit.

 **Shared responsibility without clear ownership can fail.**

CLEAR PLANS
BETTER OUTCOMES

OWNERSHIP

Follow-up and ownership: who holds the patient now?

- Name the owner out loud. "The diabetes clinic" is not a person; "Dr Rao's team, reviewed on the 12th" is.
- Book the follow-up before the patient leaves - not "please call to arrange".
- Close the loop: confirm the primary care team actually received the summary.
- Track the ones who do not arrive. In NCDs, the no-show is the highest-risk patient in the clinic.



PARTNERSHIP

The patient and family are part of the handover team

EQUIP

One list, always current

A single medicines list, recent investigations, the patient carries to every visit - paper or phone, but only one.

INVITE

Ask three questions

Encourage: What is my main problem? What do I need to do? Why is it important that I do it?

INCLUDE

Whoever fills the box

The person who actually organises the tablets at home must be in the conversation.

Human Connection matters

Even technically correct care can fail if communication is poor. A few minutes of clear explanation may prevent weeks of confusion after discharge.



SECTION 05

Make it stick

Red flags, the five-item bundle, and the one transition your team fixes first.

SAFETY CHECKS

Red flags: stop the transition until these are answered

A new high-risk medicine started (insulin, anticoagulant, opioid) with no teach-back done

Renal function or potassium still moving, with no repeat test booked

The patient cannot name what changed and why

No confirmed follow-up date, or no one named to act on pending results



Any one of these is a reason to pause, not a reason to hurry.

WHAT GOOD LOOKS LIKE

The safe transition bundle — five things, every time

01

Reconcile

Every medicine, every change, every reason.

02

Explain

Teach-back until the patient can say it.

03

Document

One record that travels with them.

04

Name an owner

A person, a date, a phone number.

05

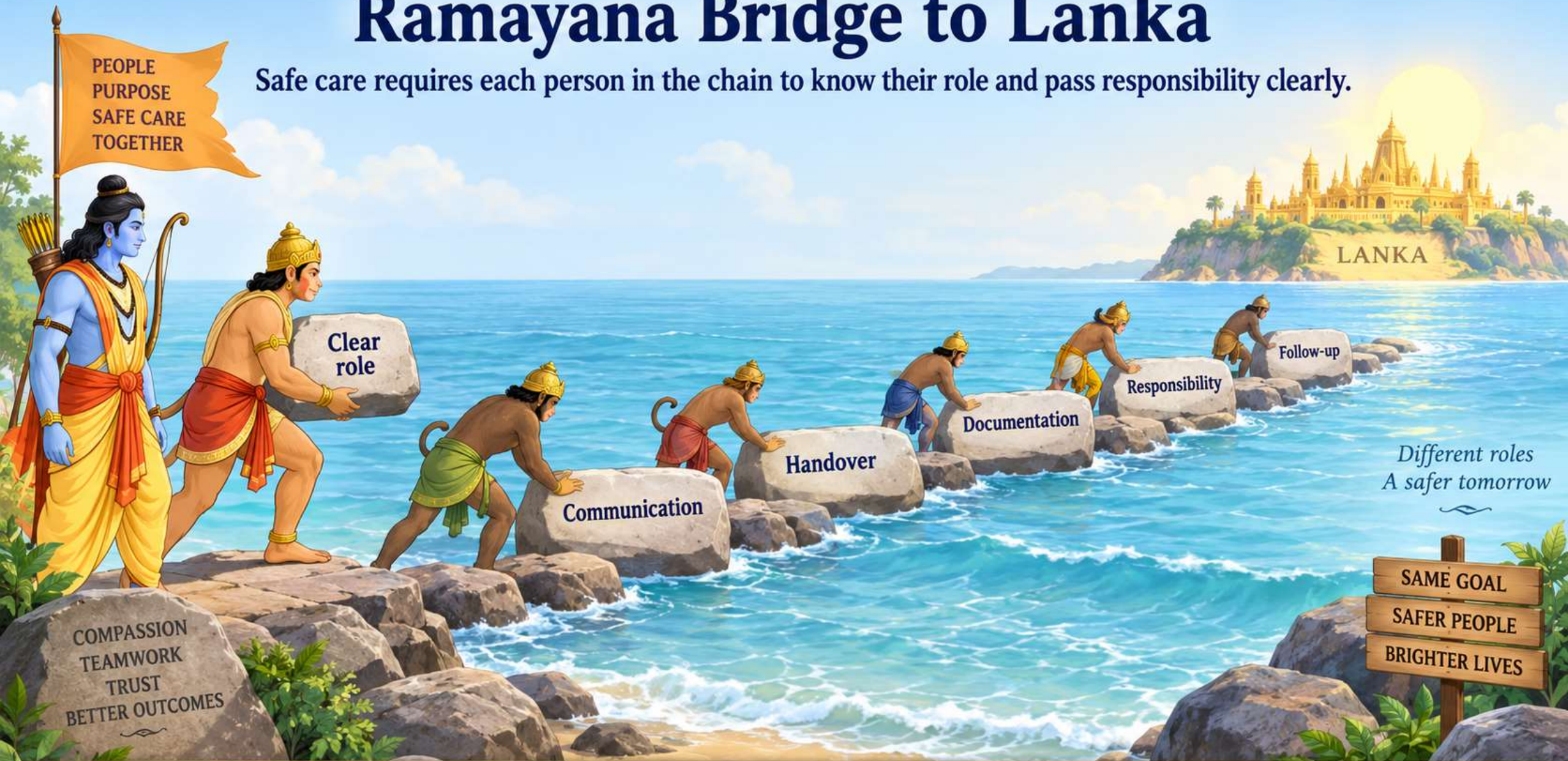
Confirm receipt

Loop closed with the next clinician.

COOKING FROM A RECIPE Nobody improvises a dish for twenty guests. A checklist is not distrust of skill — it is what lets skill work under pressure.

Ramayana Bridge to Lanka

Safe care requires each person in the chain to know their role and pass responsibility clearly.



The bridge was built stone by stone. A safe care pathway is built the same way.

MEASURE IT

If you do not measure the handover, you cannot improve it

% of discharges with medication reconciliation done

% of pending results acted on within 7 days

% with a named owner and a booked follow-up

A person and a date before the patient leaves — not “please call to arrange”.

% with teach-back documented

The patient said the plan back in their own words - understanding, not attendance.

30-day readmission and 7-day review rate

The outcome the other four move. Track the no-shows too — they are the highest risk.

***Start with two numbers, a small sample and a monthly review.
A measured transition is the one that gets fixed.***

COMMIT TO ONE CHANGE

Pick the single transition your team drops most often - and fix its baton.

