National Patient Safety (PS) Policies and Strategies for Knowledge platform on PS (SingHealth)

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World Health Organization

Analysis of National PS policies and strategies on public domain

- **Number: 20 and majority from EURO region with high level of maturity in the implementation of PS**
- **Type of policies and strategies**
  - **National PS Strategic plan**
  - **PS National program**
  - **National PS Framework**
  - **National PS Implementation Framework**
  - **National Policy on Quality and Safety**
  - **National Health Policy**

Global analysis and remarks

- **No homogenous PS policies and strategies over the world**: The structures of the policy documents differed between the countries, **both in terms of scope and design.** No clear distinction between a strategy and an action plan. **For many national policies we cannot see how the described mission relates to the overall vision or to the strategy and lack a clear description of who is the primary beneficiary of the strategy or action plan.** A way can be "Micro level" refers to patients and healthcare professionals, "Meso level" refers to management at the caregiver level and "Macro level" the highest strategic management (Government/Health department).
- **Imperative need for country to carry out in-depth situation analyses** in selected areas as part of the development of the action plan (**with the most pressing needs and challenges and what areas need priority**). Some many "narrow" definition of PS are formulated (that PS is primarily about reducing the risk of adverse events) and the other end represents a broader definition (that PS is part of the quality work of care and even broader with consideration of PS for social care services as well)
- Importance to have a **plan for implementing the action plan**, and **a follow-up model** where results can be linked to the actions outlined in the action plan
- Support and softer methods that motivate caregivers to work with patient safety should therefore be complemented by tighter regulation to ensure that the work is carried out.
- Patient safety **is closely linked to the broader term of quality in healthcare.** PS for many countries is seen as **one of several factors needed to realise the vision of creating high-quality and safe care**
- **PS as strategy to reach quality of care like "Safe care“, "Person-centred care" and "Effective care“ for Scotland or PS as one of the priority areas for quality development for New Zealand** (as collaboration with patients/consumers, support for health professionals and cost-effectiveness)
- **PS and QoC need to carried at individual, population and system levels. The possibility of follow-up is considered a strong motivated factor for caregivers to work with patient safety**
- No description of what the projects include or how they are to be implemented
- **Some countries like Canada, Finland and Ireland have included PS in health and social care services and patient partner approach**

Global analysis and remarks

- Some countries see **patient safety as the fundamental basis of the health care system**, reflected in national programs and supported by strong legislation in place, others solemnly **rely on quality strategies, campaigns, accreditation systems and inspections**.
- It seems some countries have **funding but no action plan**, while others have **expertise but no funding**. Some national PS policies/strategies have described actions whose **granularity and timescales are heterogeneous. These actions need to be combined with predefined monitoring indicators for their assessment**
- **Information on national programs is not readily available in all countries** some publish reports and data online, however, **not always in fully transparent manner**.
- **The information available is mainly relevant for the experts and healthcare professionals and not for the general public**.
- To learn about national programs in other countries and accelerate the exchange of best practices, **having a good network of involved experts appears to be essential**.
- Some countries like **Denmark, Sweden, Norway, Finland and New Zealand** have opted for a fault-free liability system in order to encourage declaration and analysis of adverse events

Global analysis and remarks: key strategies

- **Safety culture of patients and professionals**: the maturity level varies greatly from country to country and even from institution to institution within the same nation. The level for effective and sustainable implementation strategies varies as well. Particularly organizational hierarchical structures / thinking, fear of reporting due to legal prosecutions and fear of reprisals by the employer, or negative judgements by colleagues have been called out for inhibiting culture changes. Pre-requisites are legal acts to protect employees for health care organizations, professionals, and patients, which additionally support educational programs.
- **Critical-incident Reporting-systems**: as the ultimate method for patient safety but issues of trust in the systems-management (e.g., government involvement), fear of legal consequences, and quality of data.
- **Importance of storytelling to enhance professional competence through experience**. As learning systems to implement for primary care and patient-engagement purposes. Need to consider not just negative incidents but positive incidences and risk-taking. **Involvement of patients, training and experience feedback need to be considered as crosscutting to all focuses**
- **Leadership efforts**: Allow professional autonomy and foster staff awareness as well as training regarding reporting-systems and behaviors.
- **Monitoring indicator as regards reduction of anticipated risks**

Global analysis and remarks

- The approach of **patient partner** is considered as advanced strategy and including the way to capture patient experience through patient surveys and in general for **health and social care services**. **It is the pathway to listen to and act on the voice of patients**

- **Psychological support** specifically for health workers is as well-advanced strategy and **it seems person-centered approach to design health services is considered only when the health system is mature enough** and allows the real consideration for **PS in all services and at each level of the health system**

- For some countries is not enough involvement of **primary care and medico-social sectors**

Factors for a successful implementation

- The various health professionals and patient associations need to be informed and involved to be really committed to the PS programme.
- Convergence between the various safety cultures inherent to each profession is necessary to avoid any compartmentalized damage
- The understanding of crosscutting approaches to risk management during a patient's care pathway is totally critical.
- Communication on the ways the programme's goals and measures are communicated is vital.
- Appropriation from concerned stakeholders is the strength of the effective implementation and National PS policies/strategies need to be followed by national policy dialogue with all stakeholders (this part or process is missing or not reported)

Level of maturity of national PS policies/strategies

- **The patient as an actor of his/her health to design "a culture of partnership or patient partner"**. Some country like France has an annual implementation event **"patient safety week".** The need to look **at the whole patient journey rather than focusing on silos in service delivery**
  Scotland using **patient safety stories**, the 'What matters to you?' initiative was launched to enhance patient safety and patient experience. **Bringing a human side to patient safety work offers an opportunity to reflect on experiences.** And **Person-Centred Health and Care Collaborative** focusing **on relationships and patient stories** as a significant component of the big picture within quality healthcare. And finally the **Whole System Patient Flow Improvement Programme** to ensure that patients receive **the right care, at the right time, in the right place, by the right team, every time**.

- **Decree or legislation on adverse events with the mandatory reporting of the adverse events** (events resulting in death, or life-threatening conditions or definitive incapacities) occurring in **healthcare and medico-social organisations and in primary care**

- Training on feedback (Incorporating safety questions into patients' pathways) and medical simulation (part of CDP) and identification of leaders and champions at the local level

- Part of assessment any specific actions to reduce any unidentified social and territorial inequalities and outcomes measurement like mortality, rehospitalization, patient experience indicators, adverse events and with special focus on risks (including in digitalization of care, telemedicine and mechanisms for coordination of care and invasive procedures additionally to risks of infection)

- **PS work has to become day-to-day business**. To avoid change fatigue, this work has to be built into the fabric of the organisation. To achieve that, **outcome measures become more important than process measures** at the stage of sustainable and sustained improvement. Focus needs **to move from reacting to existing problems to proactively managing the threats and preventing them**

A framework to analyze National PS policies and strategies

Context analysis

- What does the health care system look like in the country?
- Which actors are involved in the patient safety work?
- What does the current patient safety context look like (focusing on organisation and governance)?
- Who is the publisher of the strategy/action plan?
- Why has the strategy/action plan been developed?
- Was the development of the strategy/action plan based on a needs analysis?
- If only the action plan has been developed: has this led to some advantages or disadvantages in the implementation?

A framework to analyze National PS policies and strategies

Structure analysis

- How is the policy document structured?
- What format does the policy document have and how extensive is it?
- Which recipients or recipient levels is the policy document aimed at?
- What is the life cycle of the policy document?
- Is there a specific communication plan for communicating the policy document?

A framework to analyze National PS policies and strategies

Content analysis

- How is the concept of patient safety defined in the policy document?
- What content fills the policy document? For example, does it have a particular thematic focus? How detailed/concrete is the policy document?
- Activities that create conditions for improvement and safe care; strengthening patient participation, improving communication, educating healthcare professionals, and supporting leadership. The category of risk areas includes activities to prevent incidents and adverse events, such as ensuring adequate medical competence, access to well-functioning medical equipment and early detection of diseases.

A framework to analyze National PS policies and strategies

Process analysis

- How has the policy document been developed?
- Have there been reconciliations and anchoring during the development?
- Is there a process for the implementation, updating, follow-up and accountability linked to the policy document?
- If there is, what is included in these processes?

A framework to analyze National PS policies and strategies

Results analysis

- What possible results/effects can be derived from the policy document?
- How is the policy document perceived by various key interests?
- What foundational factors or obstacles have been observed?

Success factors and key indicators

1. Reducing hospital-acquired infections
2. Safe care processes
3. Safe medication management
4. Safe nursing
5. Safe communication
6. Safe medical technology

SEARO Region

World Health Organization

Bangladesh, National Patient Safety Strategic Plan (2018)

- The strategies:
  - To improve the structural systems to place patient safety at the center of health care from primary to tertiary level
  - To assess the nature and scale of harm to patients and establish a system of reporting and learning at the different levels
  - To take action on reported incidents and to prevent harm to patients in the future
  - To ensure a competent and capable workforce that is aware and sensitive to patient safety
  - To ensure practice of patient safety covering all the domains in health care services
  - To develop leadership skills around patient safety both at facility and national levels
  - To facilitate sustainable improvements in patient safety and risk management to prevent patient harm
  - To ensure empowerment of the patient to participate in the decision-making process
  - To develop a culture of safety at the facility level that supports and enables the above objectives
- The document indicates indicators, the outcomes expected for each strategy and who is responsible, the activities are well described and means of achieving but the way forward is not well described

Sri Lanka, National Policy on Healthcare Quality and Safety (2015)

- **UHC status and coverage level:** Sri Lanka provides free healthcare services to all the citizens irrespective of their socio-economic status or geographic location

- **PS Strategies:**
  - development of quality standards and guidelines,
  - improvement of a **patient safety orientation, and involvement of staff**,
  - improvement of the **assessment and evaluation of quality improvement**,
  - Improvement of **information and state reporting systems** and the achievement of a better value for money

- **Specific focus:**
  - Patient safety research (Evidence-based Practice) to improve data analyses to identify patient safety issues and to demonstrate that a new practice will lead to improved quality and patient safety

Sri Lanka, National Policy on Healthcare Quality and Safety

- Establishment of an **effective risk management system** and a **reporting system**
- Build up a committed hospital system which provides a **responsive and safe healing environment for patients and their families**.
- Strengthen programmers for **safe clinical procedures and processes**
- **Promoting a proactive culture** aimed at quality & safety while reinforcing interventions and energizing the staff to continue with provision of patient safety by establishing **a quality improvement Team (QIT) and work improvement Teams (WITs), sharing best practices** from the **benchmarked healthcare organizations,** Develop a mechanism to **encourage spiritual health in healthcare organizations**. Ensure participation and sensitization of staff, patients and community in **sustaining a health promoting culture in health facilities**
- **Quality and PS training:** HR executives know how to engage people at every level of the organization, and this engagement is the key to the success of any new initiative. Facilitate **continuous professional development of staff** to empower them with required knowledge, skills and attitudes. **Use mechanisms to reward creativity and innovation among staff** for quality improvement and patient safety. Design and implement activities **to support staff wellbeing and enhance job satisfaction**

Maldives, NATIONAL PATIENT SAFETY FRAMEWORK ENSURING QUALITY & SAFETY (2021)

Pre-requirements for PS

- **Establishing patient safety mechanism is expensive**
- Patient safety cannot be achieved without **system accountability and system competence**
- Commit to **mainstreaming patient safety as the fundamental cornerstone of health care delivery system**
- Establish a **culture of safety** is to ensure that leadership and the whole organization understand the basis for a focus on patient safety
- Patient safety and Quality of care have **been recognized as critical components for achieving the Universal health coverage (UHC)**
- The strategy also acknowledges that patient safety cannot be assured, unless health system is in place in a country

Maldives, NATIONAL PATIENT SAFETY FRAMEWORK ENSURING QUALITY & SAFETY (2021)

Current PS activities

- For strengthening the patient safety framework, Ministry of Health (MOH), Republic of Maldives had requested the WHO for assistance in assessing prevalent the status in the year 2016 and WHO SEARO **Patient Safety assessment tool** was used for the situation analysis in Republic of Maldives in the year 2016
- **System for on-going assessment patient safety is almost non-existent** in the country and there is **no system of incidence surveillance, reporting and learning at the National and at Atoll level**
- **The adverse events and 'near-misses' are analysed as case to case basis, more on receipt of such complaints. Most of the institutes do not have institutional arrangement for review of such happenings, nor, there is a regulatory requirement.**
- **Absence of a System of Competency Assessment and Credentialing of Health Professionals**
- **No System of Capacity Building and Continual Medical Education**
- **There is no system of assessing understanding and practices of patient safety among healthcare workers both in public and private sector**

Maldives, NATIONAL PATIENT SAFETY FRAMEWORK ENSURING QUALITY & SAFETY (2021)

National PS Framework: Engage the patient as equal partner in patient safety by active involvement and empowerment for ensuring that provided healthcare is respectful and responsive to their preferences, needs and values.

Following are the strategic objectives:

1. To establish the institutional arrangements and strengthen the clinical governance to place patient safety at core of national, subnational and facility priorities.
2. To ensure competent and capable work force sensitive to patient safety needs.
3. To implement patient safety in its all modalities that is prevention, diagnosis, treatment and follow up across all levels of care and programs.
4. To reduce patient harm generated by unsafe medication practices and errors.
5. To engage the patient and patient groups to improve patient safety and quality.
6. To establish Patient safety event reporting system and promote patient safety research

To establish the Institutional arrangements and strengthen the clinical Governance to place patient safety at core of National, subnational and facility priorities

National Patient Safety Committee will be constituted under aegis of Ministry of Health and it will be an integral part of Maldives Quality Commission (As mandated under the Health Services Act and Health Master Plan 2016 – 2025). Since at present Maldives Quality commission is not notified, **an Interim committee could be constituted at in the Ministry of Health for Patient Safety**

Maldives, NATIONAL PATIENT SAFETY FRAMEWORK ENSURING QUALITY & SAFETY (2021)

- The **Interim committee of Patient safety** will have experts of IGMH, representatives from Maldives Medical Association, Maldives nurse association, Health protection agency, state trading organization, Maldives Blood services, regulatory authorities, insurance agencies, patient / civil society organization, private institutions, representatives from at least two atoll hospitals and two health centres and other relevant stakeholders
- Considering the geographical spread of the country, it is recommended **to have a focal point for patient safety at Atoll level**. The focal point will be responsible for effective implementation of Patient safety framework goals in their respective Atolls as per directions of National Patient Safety Committee/ Interim committee. it is required to designate a **focal point for patient safety at facility level** also
- Patient safety concepts and principles should be **integrated in all disease control program** considering safety of both providers and patients.
- Govt. funded health insurance schemes should **incorporate provision for payment based on patient safety performance/ safety indicators** such as hospital acquired infection rates, medication errors and use of safe surgery checklist
- Quality commission and commissioner to establish **technical Advisory committee, Licencing unit, Accreditation units, Quality Assurance & Improvement unit, Patient safety unit,** etc
- Awareness and capacity building programme for patient safety laws and regulations will be developed
- **Minimum patient safety standards and norms should be incorporated in the Quality of care Standards**. The standards should be capable of measuring patient safety issues objectively and adequately such as fire safety, structural safety, seismic safety, medical device safety
- **Elements of patient safety will be introduced in Job Specifications of health workforce**. Its practice and monitoring would be used to evaluate performance of different categories of health care professionals.
- Patient safety skills should be **incorporated in the evaluation criteria for licencing and relicensing assessment for healthcare professionals**
- Patient safety will be **introduced in the educational curriculum (as separate module) of health care professionals viz. nursing, para medical etc. as ongoing education and capacity building of next generation health professionals.** Specific number of mandatory credit hours will be introduced for patient safety and linked with re-licencing norms of all category of health workers
- **Patient safety benchmarking schemes**, organising team-building activities and **simulation exercises for patient safety at the facilities** and use of quality tools such as PDCA, mistake proofing, Lean etc. for the improvement
- Mechanism for feedback on satisfaction and grievance redressal of healthcare staff will be **introduced at facility level for promoting blame free culture**.
- Health care staff will be supported for financial and legal liabilities in case of patient safety event and/or in case of patient safety reporting. This will be achieved through providing indemnity cover.
- Electronic health records system will be promoted at all levels of healthcare with provision of **extraction for patient safety information from administrative and clinical records**. EHR data will also be used for detecting patient safety triggers.
- Surveillance system for Healthcare Associated Infections will be established and HAI data will be collected and analysed by the units responsible for patient safety reporting

Maldives, NATIONAL PATIENT SAFETY FRAMEWORK ENSURING QUALITY & SAFETY (2021)

- A **comprehensive communication strategy**, which promotes patient safety within the health facility, will be developed involving all stakeholders. The communication strategy will be targeting both patient, carer, community as well as care providers
- To engage the patient and patient groups to improve patient safety and quality
- **Citizen charter** will be strengthened, and **patient safety will be included as integral part of the patient rights in the country**. It would broadly include right to be treated without any actual or potential harm, right to know safety and quality performance, right to refuse and ask for a second opinion, etc. **Citizen's charter will be disseminated through health system channels as well as through public display, mass media channels**
- A comprehensive Information, Education and Communication (IEC) plan to raise awareness of masses on patient safety issues will be developed. Information will be disseminated through multiple channels viz. mass media, celebrating patient safety day/week, public displays and through development of dedicated patient safety portal/ Application.
- **Rating/ ranking of healthcare facilities based on safety and quality performance will be undertaken at regular interval**. It will be linked with compliance to patient safety standards, quality accreditation status and patient safety key performance indicators
- Patient safety portal/patient safety app. will have multiple interfaces such as safety information regarding specific procedures, advisory to healthcare professionals on specific high-risk practices, new treatment modalities, regular on line capacity building about safety information and their implementation.

Maldives, NATIONAL PATIENT SAFETY FRAMEWORK ENSURING QUALITY & SAFETY (2021)

Focus on Patient engagement

- Practice of involving patient and families in their care and decision making will be promoted through various strategies. This can be through **involving campaigns, instituting practices like birth companion, involving family members in counselling, informed decision making, second opinion as patient right**, etc.
- Formal process to recognise/recruit the patient groups working in general or for specific disease conditions will be established. This would also include explicit criteria for recognising and recruiting such groups. A registry of patient groups listed and recognized with Govt will be developed.
- A process to identify and recruit the local patient partners at facility level will be evolved. It can be **individuals who has experienced the facility-based care (as a patient, family member or caregiver) and who can be helpful in improving the patient engagement and safety in the hospital**. The qualification criteria, and role and responsibilities of patient partners would be defined.

India, National Patient Safety Implementation Framework (2018-2025)

- Fragmentation of laws, regulations, policies and strategies on the quality of care
- No definition of the rights of the patients.
- National Health System Resource Centre (NHSRC) for specific quality and patient safety needs of public health institutions.
- Limitation to indicators for quality of care and only for Reproductive, Maternal, Neonatal and Child Health (RMNCH).
- Very small proportion of hospitals taking in consideration PS measures.
- Demand from population side is not adequate enough to influence policy directions.
- Accreditation mechanisms for healthcare facilities are in place.
- The public institutions are not currently actively involved in NABH Accreditation.
- Public Hospitals are undertaking accreditation against National Quality Assurance Standards (NQAS) developed by MoHFW. Both NABH and NQAS standards are accredited by ISQUA.
- Mechanisms of assessing the overall burden of unsafe care in the country exist for some programmes, such as Adverse Events Following Immunization (AEFI), Pharmacovigilance Program of India (PVPI), etc. but not for all. •
- A patient safety incident surveillance and a system of reporting and learning from all adverse events and “near misses” at national and sub-national levels exist for certain events like needlestick injuries, AEFI, Pharmacovigilance, Haemovigilance, Death audits etc. but not for all. Root cause analysis done for Maternal deaths, neonatal deaths, AEFI, etc. but not for all diseases/ conditions. But not all Institutes follow the same standards all the time as no regulatory mechanisms exist.
- Health workforce curriculum are not homogenous in the country
- Strategic Objective 1: To improve structural systems to support quality and efficiency of healthcare and place patient safety at the core at national, subnational and healthcare facility levels. Strategic Objective 2: To assess the nature and scale of adverse events in healthcare and establish a system of reporting and learning. Strategic Objective 3: To ensure a competent and capable workforce that is aware and sensitive to patient safety. Strategic Objective 4: To prevent and control health-care associated infections. Strategic Objective 5: To implement global patient safety campaigns and strengthening Patient Safety across all programmes. Strategic Objective 6: To strengthen capacity for and promote patient safety research
- Indicators clearly identify to assess PS progress in their framework

AFRO Region

World Health Organization

2022 Kenya, National Policy on Patient Safety, Health worker safety and Quality of Care

- **Current initiatives:** the Kenya Quality Model for Health, the Kenya Quality of Care Framework, the Joint Health Inspection Checklist, the National Infection Prevention and Control Strategy, the National Policy and Action Plan on the prevention and containment of antimicrobial resistance and the Categorization guidelines
- The policy provides **a pathway through which optimal levels of patient safety will be achieved as we strive towards attainment of Universal Health Coverage**
- Patient safety has been well articulated in the revised **Kenya IPC Policy (2020-2025) and IPC Strategy (2020-2025),** several IPC trainings packages and tools. Medication and patient safety are a core component of pharmacovigilance as outlined in the **Kenya Guideline on the Safety and Vigilance of Medical Products and Health Technologies 2019**
- Health worker safety is well articulated in the **Occupational Safety and Health Act No. 15 of 2007**, the **National Occupational Safety and Health Policy (May 2012) and the Occupational Safety and Health Policy Guidelines for the Health Sector (July 2014).**
- Kenya lacks an **integrated comprehensive Policy on patient safety, quality and health worker safety and hence the need for this policy**
- **National Patient Safety Advisory Committee (NPSAC)** is tasked with overseeing matters pertaining to patient safety. **However, a gap exists in mechanisms for addressing matters concerning health worker safety in the health sector which are currently under the umbrella of the Division of Occupational health and safety.** Need to develop a **linkage between the NPSAC and the Division of Occupational health and safety to ensure issues of patient and healthcare workers safety are addressed as an entity**
- Process of **national patient safety situation analysis** and collection and analysis of other designated patient data
- **Training: Curricula on patient and health worker safety and quality of care have not been developed**. However, a module on patient safety has been incorporated within the IPC curriculum
- **Strengthen intersectoral collaboration on health worker and patient safety**, with appropriate worker and **establish a blame-free and just working culture through open communication, supported by legal and administrative protection from punitive action when reporting adverse safety events**
- Develop integrated metrics of patient safety, health worker safety and quality of care indicators, within health information systems providing comprehensive data
- Routine incident reporting on patient safety and Healthcare worker incidence shall inform areas of emphasis for systematic measurement and possible intervention

2017-2021 Ghana National Healthcare Quality Strategy

- Include mental healthcare and traditional medicine
- Patient's charter
- Patient safety guidelines
- Komfo Anokye Teaching Hospital has implemented the WHO Patient Safety initiative under the African Partnership on Patient Safety (APPS)
- Improve patient safety, client satisfaction, and participation of patients and the community in quality governance structures at all levels
- Indicators for PS: improvement in 50% of patient safety indicators nationwide between Q1/2019 and Q4/2021; No. surgical wound infected among inpatients / total no. surgical interventions among inpatients; Number of patients who develop pulmonary embolism or deep vein thrombosis within the agreed hours of surgery /Total number of post-operative records reviewed; Number of patients who develop haemorrhage or haematoma postoperatively /Total number of postoperative records reviewed
- Train untrained health workers in the public, private service delivery sites and teaching hospitals on the existing national patient safety policy
- Provide basic tools to facilitate scale-up of the implementation of the existing national patient safety policy to all public and private service delivery sites and to all teaching hospitals

Others African countries

2007 South Africa, National Policy on Quality of Care in healthcare

- PS only to reduce errors in health care result in injury to patients.
- Focus on health professionals training to avoid the consequences of errors

2014 Guinea, National Health policy

- Not yet PS and QoC strategies but it is planned with the consideration of health professionnels safety

2016 Ivory coast, Policy to improve QoC and health services

- No specific PS activities are mentionned and PS is insuffisant based on the survey (30% of compliance only related to hygiene)

2019 Togo, Policy on quality of health services

- Nothing about PS and QoC

WPRO Region

World Health Organization

2021 Australia, National safety and quality health service 2021 (Action plan)

Safety and quality systems are integrated with governance processes to enable organisations to actively manage and improve the safety and quality of health care for patients

Policies and procedures: maintain the currency and effectiveness of policies, procedures and protocols and review compliance with legislation, regulation and jurisdictional requirements

Measurement and quality improvement: Identify safety and quality measures, and monitor and report performance and outcomes; Identify areas for improvement in safety and quality; Implement and monitor safety and quality improvement strategies; Involve consumers and the workforce in the review of safety and quality performance and systems. Timely reports for beneficiaries: the governing body, the workforce, consumers and the local community and other relevant health service organisations

Risk management: . Identifies and documents organisational risks; uses clinical and other data collections to support risk assessments; acts to reduce risks; regularly reviews and acts to improve the effectiveness of the risk management system; reports on risks to the workforce and consumers; plans for, and manages, internal and external emergencies and disasters

Incident management system: Supports the workforce to recognise and report incidents; Supports patients, carers and families to communicate concerns or incidents; Involves the workforce and consumers in the review of incidents; Provides timely feedback on the analysis of incidents to the governing body, the workforce and consumers; Uses the information from the analysis of incidents to improve safety and quality; Incorporates risks identified in the analysis of incidents into the risk management system; Regularly reviews and acts to improve the effectiveness of the incident management and investigation systems; Uses an open disclosure program that is consistent with the Australian Open Disclosure Framework; Monitors and acts to improve the effectiveness of open disclosure processes

Feedback and complaints management: processes to seek regular feedback from patients, carers and families about their experiences and outcomes of care; processes to regularly seek feedback from the workforce on their understanding and use of the safety and quality systems; Uses this information to improve safety and quality systems; Encourages and supports patients, carers and families, and the workforce to report complaints; Involves the workforce and consumers in the review of complaints; Resolves complaints in a timely way; Provides timely feedback to the governing body, the workforce and consumers on the analysis of complaints and actions taken; Uses information from the analysis of complaints to inform improvements in safety and quality systems; Records the risks identified from the analysis of complaints in the risk management system; Regularly reviews and acts to improve the effectiveness of the complaints management system

Identifies groups of patients using its services who are at higher risk of harm; improve the cultural safety and cultural competency of the workforce to meet the needs of its Aboriginal and Torres Strait Islander patients

2009-2015 New Zealand, Health strategy

Relationships between managers and clinicians, who were expected to work cooperatively to prioritise safety, deteriorated in 2009. There was no organisation with dedicated expertise, quality was not at the centre of all policy and service work, quality focussed services were not built, there was no national infrastructure to support it, and the DHBs were not required to provide evidence of the implementation of best practice

The second and current phase followed the 2010 emergence of the Health Quality & Safety Commission, which supports a suite of patient safety programmes. Senior doctors are insufficiently supported to lead safety improvement, and they tend to not prioritise it. Risk control work in NZ is being compromised by intense throughput pressure on nursing and medical staff at all levels.

Strategies address both common specific risks, such as those involving surgery, medications, infections, and falls; and practices targeting generalised risk, such as team-training and detecting adverse events

EURO Region

World Health Organization

2022 Finland, The Client and Patient Safety Strategy and Implementation Plan 2022–2026

The Client and Patient Safety Strategy and its Implementation Plan 2022–2026 will promote inclusion, measures that strengthen safety, and the management of safety culture in Finland

The vision is that Finland will be a model country for client and patient safety in 2026 — we will prevent avoidable harm. This means that we will introduce recommendations based on the best research data so that they will benefit the management, professionals, patients and clients in all organisations at all levels of operation.

In order for the vision to be realised, it has been divided into four strategic priorities. There are three objectives under each priority, and achieving these objectives will strengthen client and patient safety in practice. The Strategy includes an Implementation Plan so that the objectives can be translated into everyday activities right from the start of the strategy period. The strategic priorities, objectives and measures have been drawn up in such a way that the vision can be achieved.

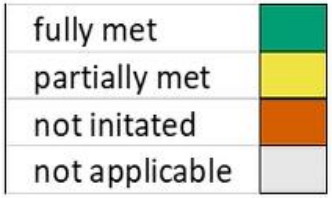
The implementation of the Strategy will be monitored using the indicators selected for the purpose.

The Strategy and its Implementation Plan have been prepared for the use of healthcare and social welfare professionals, the parties leading and supervising the activities, political decision-makers and clients, patients and their families. The Strategy is intended for both public and private actors and all stakeholders promoting safety

2022 Finland, The Client and Patient Safety Strategy and Implementation Plan 2022–2026

- Promotion of PS in Finland started in 2009 but the programme have been discontinued in 2014
- Strategy integrates social welfare clients and healthcare patients
- Finnish Centre for client and PS in charge of QoC and PS with an action plan
- The strategy have been established based on 8 workshops with 100 participants to consult all stakeholders and focus on the systematic approach of **inclusion and engagement**
- The main goal is eliminating all avoidable harms
- Including patient and family members
- Consider public and private parties
- In alignment with Health and social services reform
- 4 Strategic priorities: clients and patients, training of professionals, safety in all organizations, enhanced best practices
- Well-being services county reform
- National, regional and services levels
- Key indicators in place and monitoring of progress on social welfare services
- In 2024 target to have at least 60% of service organisers have recorded clients
- Implementation by Centre for client and PS including monitoring and reporting (every 2 years). One report in 2024
- Video clips for different target groups, social media messages on the ministry channel and from Centre for client and PS
- **Still behind in term of implementation: PS training for healthcare personal, not enough financial resources for PS and lack of guidelines on psychosocial support (link to CEQ)**

Finland self assessment year 2022



Policies to zero avoidable harm	1	2	3	4	5
1.1 Policy, strategy & implementation					
1.2 Resource mobilization & allocation					
1.3 Protective legislative measures					
1.4 Standards, regulation & accreditation					
1.5 WPSD 17.9. & Global PS Challenges					

High-reliability health system	1	2	3	4	5
2.1 Transparency, openness & No blame					
2.2 Good governance for HC-system					
2.3 Leadership capacity					
2.4 Human factors & system resilience					
2.5 Emergencies & extreme adversity					

Safety of clinical processes	1	2	3	4	5
3.1 Risk-prone clinical procedures					
3.2 GPSC: Medication Without Harm					
3.3 Infection prevention & control, AMR					
3.4 Medical device, medicine, blood, vaccine					
3.5 Primary care & transitions					

Patient and family engagement	1	2	3	4	5
4.1 Co-development, policies & programmes					
4.2 Patient experience for improvement					
4.3 Patient advocates & PS champions					
4.4 PSI disclosure to victims					
4.5 Information & education					

Worker education, skills & safety	1	2	3	4	5
5.1 PS in professional education & training					
5.2 Centres of excellence for PS education					
5.3 PS competence regulatory requirements					
5.4 PS in appraisal system of workers					
5.5 Safe working environment					

Information, research & risk management	1	2	3	4	5
6.1 PS incident reporting & learning system					
6.2 PS information systems					
6.3 PS surveillance systems					
6.4 PS research programmes					
6.5 Digital technology for PS					

Synergy, partnership & solidarity	1	2	3	4	5
7.1 Stakeholders engagement					
7.2 Common understanding & commitment					
7.3 PS networks & collaboration					
7.4 Multisectoral initiatives for PS					
7.5 Technical programmes & initiatives					

World Health Organization

2013 France, Programme national pour la sécurité des patients 2013 / 2017

- Risk management approach and relevance analysis
- In place: Good practice recommendations and vigilances, infection prevention and medication safety
- Feedback mechanisms and systemic approach of harms and incident management with coordination of all professionals
- Major risks and harms due to **organizational dysfunctions or lack of interpersonal communication**
- **Certification process for health care institutions**
- **Quality indicators development**
- **Implementation of Continuous Professional Development**
- **Accreditation of doctors in high-risk specialties**
- **Optimization of care paths**
- **Security culture establishment**

The national patient security plan describes all general and operational objectives

Ireland, Patient Safety Strategy 2019-2024

- The strategies (Good intentions). They are well described in the document but we don’t know how, by who and an action plan is missing to implement these strategies:
  - Empower and Engage Patients to Improve Patient Safety
  - Empower Staff to Improve Patient Safety
  - Anticipate and Respond to risks to Patient Safety
  - Reduce Common Causes of Harm
  - Measure and Learn to Improve Patient Safety
  - Provide effective Leadership and Governance to Improve Patient Safety
- Each commitment is related to series of action and in this way the strategy includes an action plan
- Improvements are being made in response to the annual National Patient Experience Survey (but we don’t know any details in the document)

UK, Patient Safety Strategy 2019-2022

- Continue to promote safety culture through well described priorities
  - Continue to invest in leadership to ensure teams are confident, curious and empowered with patients at the centre of everything they do
  - Ensure reporting and speak up systems are easy to use, responsive and inform organisational learning
  - Not tolerate bullying and harassment in teams which can lead to patient safety incidents/poor care not being reported for fear of retribution
  - Listen to patients, their advocates and carers and develop strategies to ensure they can inform and influence the patient safety agenda for the Trust
- Improve its understanding of safety by drawing insight from multiple sources of patient safety information (Insight) and develop a positive and proactive safety culture and reduce the number of Patient Safety Incidents resulting in harm
- Equip patients, staff and partners with the skills and opportunities to improve patient safety throughout the whole system (Involvement). Including the work with patients, carers and key partners to continuously improve patient safety and to ensure staff are equipped with the appropriate patient safety knowledge and skills to embed an organisational wide culture of learning from patient safety incidents
- Design and support programmes that deliver effective and sustainable change in the most important areas (Improvement) like ensure a culture of continuous improvement and to work with the wider community to improve patient safety

NORWAY, PS National Program 2014-2018

- It started with a campaign in 2011. A national patient safety campaign was commissioned by the Ministry of Health. The aims were to: 1) reduce patient harm, 2) build sustainable structures for patient safety and 3) improve patient safety culture. Targets areas were: falls, urinary tract infections, central line infections, pressure ulcer, prevent overdose and suicide, stroke treatment, safe surgery/postoperative infections, medication reconciliations, drug review in home care and in nursing homes. A secretariat was established.

- The patient safety culture was studied in 2014 by an international Safety Attitude Questionnaire to 77.457 health personnel in 2.372 units. Response rate was 62%. Results show that 56% of the units report a ripe safety climate. **International experience tells that units without a ripe climate have higher risk for adverse events.**

- A national program for patient safety was launched in 2014. Based on the experiences from the campaign, a national program 2014-18 was launched. It continues with a secretariat in the Directorate of Health, a steering group and expert groups, same target areas and goals. It was also focus on involvement of patients and of the municipalities. Examples of national targets: Reduce incidents of harm by 25% from 2012 until 2019, increase 30-days survival after hip fracture by 2% and at least 80% of respondents from health units will report a ripe patient safety climate.

SCOTLAND, The Scottish Patient Safety Programme (SPSP) - 2008

- National quality improvement programme that aims **to improve the safety and reliability of care and reduce harm**
- The programme has expanded to support improvements in **safety across a wide range of care settings including Acute and Primary Care, Mental Health, Maternity, Neonatal, Paediatric services and medicines safety**. Extension **to each new programmes had its specificities as they needed to undergo some adaptation to the context of their care setting**. It was harder for local Primary Care teams to attend national learning sessions and so more was done regionally and virtually. **It was also recognised this is different type of care that will require new solutions.** Primary care clinical teams to be developing their **safety culture and achieving reliability in three high risk areas by 2016. For mental health,** it was designed from scratch, and it was decided to **co-design the programme priorities alongside the service users, carers, clinicians, and the evidence. Patient Safety Climate Tool** was developed by a service-user led focus group and supported by the programme team
- Political and governmental leadership embraced quality improvement as the way forward for Scotland
- The programme will be extended to community dentistry, community pharmacy, and community and district nursing.
- Smaller units where multidisciplinary working is the norm, such as Intensive Care Units, were able to deliver improvements most quickly. **In 4 years of SPSP work, surgical mortality was reduced by a third after 20 years of stagnation**
- **Issue with their reporting incident system with the scale-up of the programme. Most heath boards submit their data in modified excel spread sheets to HIS where the data get amalgamated into quarterly reports**
- Key success and lesson learned: moving from traditional programme-specific site visits to a combined site visit in which the **whole Patient Safety Programme visits the whole NHS board rather than conducting multiple visits by each strand of the safety work**. This also gives the boards an opportunity to bring all strands of their safety improvement work together

AMRO/PAHO Region

World Health Organization

CANADA, A policy framework for patient safety 2018 - 2023

- The following guiding principles for the Policy Framework reflect the current values and desired goals underlying patient safety policy in Canada: Patient care is as safe as possible across the country, and efforts are made to prevent, respond to and learn from a patient safety incident. Jurisdictions and organizations have mechanisms for measuring and monitoring safety; Patients, families and the public are actively engaged and empowered; Supportive and engaged leadership promotes a culture of safety; A caring and just culture is established at all levels of Canadian healthcare ; and the health workforce is engaged and supported.
- Safe patient care is a core value of Canadian healthcare (Commission on the Future of Health Care in Canada 2002). Moving the bar on patient safety in Canada involves system-wide dedication. If unanticipated patient harm occurs, then steps are taken to ensure that patients and their families are provided with information about the incident in a timely, honest and transparent manner. Reasonable efforts are made through the policy levers to ensure that the incident is not repeated (Leape et al 2009). Processes of a patient-centred healthcare system support those involved in a patient safety incident, including healthcare providers, patients and their families so they will experience a transparent analysis of the incident
- Patients and their families need mechanisms for safe reporting of patient safety incidents along with supports (e.g. counselling) to assist them with the aftermath of a patient safety incident.
- The role of measuring, monitoring, and shared learning for quality and safety outcomes is becoming increasingly recognized by Canadian provincial/territorial/federal governments but not been substantive, and not system-wide improvement in patient safety. Principally, patient safety measures or scorecards are based on past patient safety incidents. While important lessons are learned from an analysis of past patient safety events, there is a need for a data infrastructure that supports real time monitoring, learning, and evidence-based quality improvement
- Patients and families are actively engaged and empowered
- Supportive and engaged leadership promotes a culture of safety
- A caring and just culture is established at all levels of Canadian healthcare (patient safety in Canada is limited to the acute care setting). There is a shortage of information about patient safety issues within mental health including incidences of stigma and overmedication. Patient safety in home care, primary care and long-term care facilities also requires further examination
- Patient safety incidents occur during transitions in care such as between healthcare providers and caregivers, during changes to service provision (e.g. discharge from acute care services to community-based services), or between different jurisdictions
- The health workforce is engaged and supported
- Policy levers are implemented and monitored: Legislation, professional regulation, standards, organizational policies and public engagement
- **The Policy Framework incorporates the unique social, political and economic contexts across Canada that underscore policy decision-making and the principles that guide patient safety policy development and implementation.**

Areas cover in National PS Policy & Strategy

Countries	Type of National PS Policy &Strategy	Year	PS Assessment methodology	PS Situation Analysis	PS Action plan for implem entation	PS Assessment tool	Integration of PS in all disease control programme	Quality commission and commissioner	Reporting incident system (PS indicators)	PS research	Focal points for PS or National patient safety committee
Kenya	PS, Health worker safety & QoC policy	2022	No	**Yes and in process**	No	TBD	TBD	TBD	**In process**	TBD	National Patient Safety Advisory Committee (NPSAC)
Maldives	PS framework	2021	Planned	Planned	Planned	Planned	Planned	Planned	Planned	Planned	Planned
Togo	Policy on quality of health services	2019	No	No	No	No	No	No	No	No	No
Ivory coast	Policy to improve QoC and health services	2016	No	No	No	No	No	No	No	No	No
Sri Lanka	PS & QoC Policy	2015	**Quality standards and guidelines**	TBD	TBD	**PS orientation M & E of quality improvement**	**PS culture**	**A quality improvement Team (QIT) and work improvement Teams (WITs)**	**In place (improvement)**	**In place Evidence-based practices**	No
Guinea	Health policy	2014	No	No	No	No	No	No	No	No	No
South Africa	Policy on QoC in healthcare	2007	No	No	No	No	No	No	No	No	No

World Health Organization

Areas cover in National PS Policy & Strategy

Countries	Type of National PS Policy &Strategy	Year	PS Assessment methodology	PS Situation Analysis	PS Action plan for implementation	PS Assessment tool	Integration of PS in all disease control programme	Quality commission and commissioner	Reporting incident system (PS indicators)	PS research	Focal points for PS or National patient safety committee
Finland	Client and Patient Safety Strategy and Implementation Plan Hard regulating / state driven	2022-2026	**Quality management plan and how high patient safety should be ensured**	In 2024	**Yes**	**Yes**	**Yes**	**Yes through the Centre for Client and PS**	**Yes and every 2 years**	**Yes**	**Yes**
Sweden	PS Action plan State driven	2020	Planned	Planned	Planned	Planned	Planned	Planned	**Patient safety reports (PSR)**	Planned	Planned
UK	Patient Safety Strategy Hard regulating State driven	2019-2022	**Yes**	**Yes**	**Yes**	**Yes**	**Yes**	**Yes**	**Yes**	**Yes**	**Yes**
Norway	PS National Program Soft regulating State driven	2014-2018	TBD	**Yes**	TBD	**Caregivers can easily click through to different priority areas and proposed measures for improved patient safety**	**Yes**	**Yes**	**Yes**	TBD	**Yes**
Scotland	The Scottish Patient Safety Programme (SPSP) State driven	2008	**Voluntary from health providers**	**Yes and with iterative approach**	**Already fully implemented and under improvement process**	**Patient Safety Climate Tool**	**Yes and with an iterative way**	***Scottish Patient Safety Alliance* (Scottish Government, NHS Scotland, the Royal Colleges and other professional bodies, the Scottish Consumer Council and the Institute for Healthcare Improvement (IHI)**	**Yes. quarterly reports**	**Yes**	**SPSP programme manager, who played a key role as part of the leadership and core coordination and the delivery team at Board level**

Areas cover in National PS Policy & Strategy

Countries	Type of National PS Policy &Strategy	Year	PS Assessment methodology	PS Situation Analysis	PS Action plan for implementation	PS Assessment tool	Integration of PS in all disease control programme	Quality commission and commissioner	Reporting incident system (PS indicators)	PS research	Focal points for PS or National patient safety committee
Australia	National strategic plan for improving quality and patient safety National Safety and Quality Health Service Standards Soft regulating state driven	2014-2019 And new edition 2021	Yes	Yes	Yes and improvement	Yes	Yes	Yes but without regulatory powers, Australian Commission on Safety and Quality in Health Care	National regulations in quality and patient safety	Yes	Yes
New Zealand	PS part of Health strategy state driven	2009-2015	Yes	Yes	Yes	Yes	No	Yes, Health Quality & Safety Commission	Yes	Yes	TBD
Danemark	Danish Society for Patient Safety Independent NGO driven		Yes	Yes	No	Yes	No	TBD	Patients Own Safety Incidents Reports to the Danish Patient Safety Database	Yes	TBD
Neederlands	Independent NGO driven	TBD	TBD	TBD	TBD	TBD	TBD	TBD	TBD	TBD	TBD
Germany	Independent NGO driven	TBD	TBD	TBD	TBD	TBD	TBD	TBD	TBD	TBD	TBD
Canada	Canadian Patient Safety Institute's (CPSI) Policy Framework for Patient Safety Independent NGO driven	2018-2023	Yes	Yes	Yes	Yes	Yes	CPSI's Patient Safety "Bundle"	Yes	Yes	Yes

Areas cover in National PS Policy & Strategy

Countries	Type of National PS Policy &Strategy	Year	PS Assessment methodology	PS Situation Analysis	PS Action plan for implementation	PS Assessment tool	Integration of PS in all disease control programme	Quality commission and commissioner	Reporting incident system (PS indicators)	PS research	Focal points for PS or National patient safety committee
India	Framework for PS implementation	2015-2018	Yes partially	Yes	Yes	Yes partially	No	Yes	Planned	Planned	No
Ireland	Patient Safety Strategy	2019-2024	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes
Thailand	Not find in public domain		Yes partially	No	No	Yes partially	No	TBD	Yes	Yes	Malaysian Patient Safety Council (MPSC)
Malaysia	Not find in public domain		Yes partially	No	No	Yes partially	No	Malaysian Society of Quality in Health	Yes	Yes	

Areas cover in Patient engagement strategy

Countries	Patient engagement assessment tools	Patient partner	Patient charter for patient rights	Complaints mechanism	Recommendations for improvement in service delivery and safety	Patient safety in the educational curriculum for providers	PS in literacy for patient and their family	Preferences of patients	Capturing patient experience
Maldives	Planned	Planned (Peer support)	Planned	Planned	Planned	Planned	Planned	Planned	Planned
Sri Lanka	TBD	TBD	TBD	TBD	TBD	**Yes through CPD**	TBD	TBD	TBD
Kenya	TBD	TBD	TBD	TBD	TBD	**Not but module on PS within the IPC curriculum**	TBD	TBD	TBD
Ivory Coast	No	No	No	No	No	No	No	No	No
South Africa	No	No	No	No	No	No	No	No	No
Sweden	**PS report includes a description of the patient safety work of caregivers**	Planned	Planned	Planned	Planned	Planned	Planned	Planned	Planned
Scotland	**Yes**	**Caregivers able to participate in various PS projects**	**Yes**	**Yes**	**Yes**	**Yes**	**Yes**	**Yes**	**Yes**

Areas cover in Patient engagement strategy

Countries	Patient engagement assessment tools	Patient partner	Patient charter for patient rights	Complaints mechanism	Recommendations for improvement in service delivery and safety	Patient safety in the educational curriculum for providers	PS in literacy for patient and their family	Preferences of patients	Capturing patient experience
Finland	Yes	Yes	Act on the Status and Rights of Patients (785/1992)	TBD	Yes	Yes	Yes	Yes	TBD
Canada	Yes	Yes	TBD	TBD	Yes	Yes	Yes	Yes	Yes
Ghana	TBD	No	Yes	TBD	Yes	Yes	Yes	TBD	TBD
India	No	No	No	No	Yes partially	Yes partially	No	No	No
Ireland	Yes	Yes	TBD	TBD	Yes	TBD	TBD	Yes	Yes

Summary of the Effects of Poor Communication in Healthcare

- The main effects of poor communication in healthcare are a **reduction in the quality of care, poor patient outcomes, wastage of resources, and high healthcare costs**. Communication failures often have a negative effect on patient and staff satisfaction.

- Effective communication will:
  - Improve quality of care and patient outcomes
  - Enhance the patient experience
  - Improve patient satisfaction scores
  - Reduce the cost of healthcare
  - Reduce stress for clinicians and prevent burnout