Deep Dive – Safety

Safety

This area is defined as safe practices being routinely followed in the delivery of care as well as in facilities more broadly. Safety requires certain inputs but also depends upon provider training in safe practices and a facility culture that promotes learning and safety.

Visual Aid - Safety

Safety

Patient safety is ensured or compromised by factors related to provider competence, diagnosis accuracy, medicines, supplies, communication, and more.

**FIVE COMPONENTS OF SAFETY:**

- Procedure adherence: Procedural safety has a number of root causes related to provider adherence to proper process. A variety of checklists and tools are available to help providers improve procedural safety.
- Diagnosis: Misdiagnosis and other diagnosis errors may occur for a variety of reasons, but are generally related to uncertainty, system level failures, or faulty thinking or reasoning.

**SAFETY SYSTEMS:**

- Facility leaders should ensure that systems are in place to identify errors, understand root causes, and adapt accordingly. Leaders must create a culture where providers can raise concerns without fear of punitive action, and where everyone is valued as a key participant in improving safety.
Safety is a component of Availability of Effective PHC Services
Safety is a component of Availability of Effective PHC

Availability of Effective PHC
- Patient-Provider Respect and Trust
- Provider Availability
- Provider Competence
- Provider Motivation
- Safety

Patient-Provider Respect and Trust

Provider Availability

Provider Competence

Provider Motivation

Safety
What can you learn about Safety from the Improvement Strategies?

**SECTION 1**

What is Safety?

**What it is:** Learn more about the core principles and goals of Safety and its role in PHC improvement.


**SECTION 2**

How do I assess my performance?

**What it is:** Learn more about some indications that improvements might be relevant in your context and what you can achieve by focusing improvements on Safety.

**Vital Signs Profile:** Use the information in your Vital Signs Profile to help determine relevant areas for improvement.


**SECTION 3**

How do I get started?

**What others have done:** Learn from implementation approaches and challenges in other country contexts.

**How to succeed:** Consider your country context, what elements are not functioning properly, and what needs to be in place to support effective improvements.

**What to ask:** Use guiding questions to help determine how you might begin to plan and enact reforms in your country context.

Guided by the above considerations and relevant resources, start to build out an improvement plan with your CE lead and/or focal point.
What can my country achieve by focusing on Safety?

Goals & Outcomes

- **Improved adherence and patient health outcomes:** Safety interventions ensure that providers and care teams safely prescribe, administer, and adhere to medication and treatment protocols.

- **Better clinical outcomes and patient experience of care:** Safety interventions help to improve the accuracy and timeliness of care, ultimately supporting better clinical outcomes and patient experience of care.
Safety – How do I assess my performance?

Learn more about whether you should focus on Safety in the Vital Signs Profile
How do I assess my performance?

Use the information in the Vital Signs Profile to help determine relevant areas of improvement.

Completion of a Vital Signs Profile gives countries a holistic understanding of PHC strengths and weaknesses, a critical first step in the measurement for improvement pathway.
What are other indications that Safety might be an appropriate area of focus?

- Facilities are unable to identify, react to, and learn from safety incidents, and may not have systems to report errors or to develop improvement strategies.

- Standard safety procedures and guidelines are not followed by or accessible to providers and care teams.

- Patient information is poorly communicated across a patient's care experience, such as during hand-offs of care between primary and secondary-level facilities.
Safety - What is it?

Learn more about the core principles of Safety and what you can achieve by focusing improvements in the **What it is** section.
What is Safety?

Safety in PHC, or the practice of following safety procedures and guidelines in the delivery of PHC services and the management of PHC facilities, is a broad topic, particularly because what comprises PHC differs substantially between contexts, and data on PHC safety in LMICs are scarce.

However, regardless of the context, safety requires certain inputs, but also depends upon provider training in safe practices and a facility culture that promotes learning and safety.
**What is Safety?**

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**What should I know before beginning improvements?**

Here we have grouped Safety into five categories that address safety related to competencies, infrastructure, and facility structure and culture:

- **Medicine and Supplies Safety**
- **Diagnosis**
- **Procedural Safety**
- **Transitions**
- **Safety Systems**
What is Safety?

Safety in PHC, or the practice of following safety procedures and guidelines in the delivery of PHC services and the management of PHC facilities, is a broad topic, particularly because what comprises PHC differs substantially between contexts, and data on PHC safety in LMICs are scarce.

However, regardless of the context, safety requires certain inputs but also depends upon provider training in safe practices and a facility culture that promotes learning and safety.

What are some key steps to improving Safety?

Cultivate a culture of learning and improvement
Facility and team leaders may create an enabling environment for safety by promoting a culture in which reporting and learning from mistakes is encouraged. Further, leaders can institute quality improvement activities and performance measurement systems that capacitate staff to follow and improve on safety practices.

Implement checklists and global guidelines on safer procedures
Facility and team leaders may adapt and implement checklists such as the WHO Safe Surgery Checklist. Team leaders may also develop training programs to educate providers on safer procedures and how to reduce harm during surgeries.

Ensure availability and appropriate use of supplies
Facilities should have all necessary equipment for ambulatory care, as well as supplies to ensure safe blood donation and safe infection control.
Visual aid: Safety

Safety

Patient safety is ensured or compromised by factors related to provider competence, diagnosis accuracy, medicines, supplies, communication, and more.

FIVE COMPONENTS OF SAFETY:

SAFETY SYSTEMS:
Facility leaders should ensure that systems are in place to identify errors, understand root causes, and adapt accordingly. Leaders must create a culture where providers can raise concerns without fear of punitive action, and where everyone is valued as a key participant in improving safety.

Procedural adherence:
Procedural safety has a number of root causes related to provider adherence to proper process. A variety of checklists and tools are available to help providers improve procedural safety.

Diagnosis:
Misdiagnosis and other diagnosis errors may occur for a variety of reasons, but are generally related to uncertainty, system level failures, or faulty thinking or reasoning.

Medicine:
Prescription falsification, errors in dosage, and patient compliance issues are all factors that affect medical safety.

Transitions:
Transitions between care providers as part of patient hand offs or shift changes are moments where miscommunication can cause errors to occur.
Safety – How do I get started?

Derive information from **What others have done**, **What to ask** and **How to succeed** to help determine where and how you might begin to plan and enact forms in your country context.
Planning for improvement in your context

The guidance and recommendations described within the Safety module are not intended to provide a one-size-fits all solution.

The considerations involved in planning and implementing strategies will depend on your local context.

Sample activities

- **Consider** implementation challenges and approaches in other country contexts
- **Understand how the features of your health system**, such as how decisions get made and the role of the private sector, will impact your improvement plans
- **Identify** key elements that need to be in place to support improvements
- **Use the guiding questions in the Improvement Strategies** to spur thinking about Safety in your country context and stimulate ideas for improvement
- **Start to develop** an improvement plan
The specific considerations involved in planning and implementing strategies will depend on your local context.

The questions listed may be a useful starting place to determine how you might begin to plan and enact reforms in your context.

Sample questions

☐ What regulatory systems are in place to ensure that medicines are not falsified?
Questions to ask to help you get started

The specific considerations involved in planning and implementing strategies will depend on your local context.

The questions listed may be a useful starting place to determine how you might begin to plan and enact reforms in your context.

Sample questions

☐ What regulatory systems are in place to ensure that medicines are not falsified?

☐ How do providers monitor patients’ adherence to medicines?
The **specific considerations** involved in planning and implementing strategies will depend on your local context.

The questions listed may be a useful **starting place to determine how you might begin to plan and enact reforms** in your context.

### Sample questions

- What regulatory systems are in place to ensure that medicines are not falsified?
- How do providers monitor patients’ adherence to medicines?
- What supervision/monitoring and in-service training do providers receive regarding prescribing practices and diagnosis? Are there any guidelines or decision-making tools that are commonly used by providers for prescribing and diagnosis?
The specific considerations involved in planning and implementing strategies will depend on your local context.

The questions listed may be a useful starting place to determine how you might begin to plan and enact reforms in your context.

Sample questions

☐ What regulatory systems are in place to ensure that medicines are not falsified?

☐ How do providers monitor patients’ adherence to medicines?

☐ What supervision/monitoring and in-service training do providers receive regarding prescribing practices and diagnosis? Are there any guidelines or decision-making tools that are commonly used by providers for prescribing and diagnosis?

☐ Are there any guidelines or systems for communication between providers during transitions of care?
The specific considerations involved in planning and implementing strategies will depend on your local context.

The questions listed may be a useful starting place to determine how you might begin to plan and enact reforms in your context.

Sample questions

- What regulatory systems are in place to ensure that medicines are not falsified?
- How do providers monitor patients' adherence to medicines?
- What supervision/monitoring and in-service training do providers receive regarding prescribing practices and diagnosis? Are there any guidelines or decision-making tools that are commonly used by providers for prescribing and diagnosis?
- Are there any guidelines or systems for communication between providers during transitions of care?
- What processes are in place to learn from medical errors or near misses, and how well are they implemented in facilities?
Learn from what others have done

Drug Safety | Kenya

A standardized patient approach can be an effective way to measure drug safety.

Morbidity and Mortality Conferences | Nepal

Morbidity and Mortality conferences can support quality improvement and improve patient safety.
A 2016 Health Bill created one decentralized health system comprised of both the public and private sectors. Sub-national (county) governments are responsible for the delivery of PHC.
## Kenya: At-a-glance context

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<td>73%</td>
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Learn from what others have done: Kenya

Background

• Many low and middle-income countries struggle with creating and enforcing mechanisms to ensure drug safety

• Two important considerations help to assess drug quality:
  • Do the drugs meet quality standards?
  • Are the drugs appropriately administered based on symptoms or diagnoses?

Approach

A World Bank study in Kenya used standardized patients to explore which methods are most effective for assessing drug quality:

• **Standardized patients** are individuals who receive training to present a standardized set of symptoms (e.g. symptoms of high blood pressure)

• **Standardized patients presented symptoms to providers**, recorded the diagnosis, and collected any prescribed medications

• **Researchers compared** actual and expected diagnoses and determined accuracy of prescriptions and safety of collected medications
Learn from what others have done: Kenya

Researchers found that **17% of collected medicines did not meet drug safety specifications**, and **five medications had been prescribed inappropriately**

The study concluded that **the standardized patient approach appears to be an effective way to measure drug safety**

This study was part of the **Kenya Patient Safety Impact Evaluation (KePSIE)**, an ongoing study exploring if increased inspections will contribute to better patient safety

The **KePSIE study** is ongoing, and the results will contribute to knowledge on **how governance and surveillance can improve patient safety**

Nepal: At-a-glance context

At Bayalpata Hospital (BH) in a remote district of western Nepal, 28 Nepali staff treated 23,000 patients in one year. BH lacked a quality improvement system for healthcare delivery.

### Nepal: At-a-glance context

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<td>81%</td>
<td>15%</td>
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Learn from what others have done: Nepal

Background and rationale

• Health facilities in rural, resource-limited settings often lack simple, practical methods to improve care quality and safety.

• One such district hospital in remote Nepal lacked any “system-level” methods to improve the quality and safety of care.

Approach

To fill this gap, in 2011, the District Hospital implemented **morbidity and mortality conferences (M&Ms)**, a quality improvement method that can support both clinical and non-clinical staff to analyze the quality of patient care, including barriers to quality.

**M&Ms were held weekly during staff meetings to ensure wide participation.** Discussions focused on various inputs and practices for quality and safety, including:

• Clinical operations
• Supply chains & equipment
• Personnel & social and structural outreach efforts
Learn from what others have done: Nepal

- To ensure follow-up after the M&Ms, the hospital administrator and executor were held responsible for the implementation of any interventions proposed during these discussions.

- Examples of interventions pursued as a result of M&Ms reviewing complicated deliveries included:
  - A task shifting workshop on emergency point-care investigations to improve efficiency during high patient flow
  - Training in partograph use during labor

Learn from what others have done: Nepal

- Despite these successful interventions, challenges that surfaced from the evaluation included difficulties like implementing M&Ms on the planned weekly basis and a lack of contribution from junior staff.

- Even considering these barriers, M&Ms may be an effective QI method in limited resource settings and can identify intervention points to improve patient safety.

- To promote sustainable scale of M&Ms in other contexts, M&Ms should encourage system-level improvement and create space for staff discussion of safety improvement.

What elements should be in place to support effective improvements in Safety?
Recap: Safety

System
- Governance & Leadership
  - Primary Health Care Policies
  - Quality Management Infrastructure
  - Social Accountability
- Health Financing
  - Payment Systems
  - Spending on Primary Health Care
  - Financial Coverage
- Adjustment to Population Health Needs
  - Surveillance
  - Priority Setting
  - Innovation & Learning

Inputs
- Drugs & Supplies
- Facility Infrastructure
- Information Systems
- Workforce
- Funds

Service Delivery
- Population Health Management
  - Local Priority Setting
  - Community Engagement
  - Empowerment
  - Proactive Population Outreach
- Facility Organization & Management
  - Team-based Care Organization
  - Facility Management
  - Capability & Leadership
  - Information Systems Use
  - Performance Measurement & Management Outreach
- Access
  - Financial
  - Geographic
  - Timeliness
- High Quality Primary Health Care
  - First Contact Accessibility
  - Continuity
  - Comprehensiveness
  - Coordination
  - Person-centered

Outputs
- Effective Service Coverage
  - Health Promotion
  - Disease Prevention
  - RMNCH
  - Childhood Illness
  - Infectious Disease
  - NCDs & Mental Health
  - Palliative Care

Outcomes
- Health Status
- Responsiveness to People
- Equity
- Efficiency
- Resilience of Health Systems

Social Determinants & Context (Political, Social, Demographic & Socioeconomic)
Recap: Safety

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