Challenges in Implementing Patient Safety Incident Reporting and Learning System

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Barriers and Challenges

- ➤ Policy Level
- ➤ National Level

➤ Institutional Level

> Unit Level

Policy Level

- No formal policy and strategy
- Failure to provide incentive by recognition
- Lack of effective communication
- Narrowly based training
- Lack of faith in and support to Patient Safety activities among management personnel
- Lack of interest or incompetence of leaders
- Misunderstanding about the concept of Patient Safety
- Delay or non-implementation of Patient Safety team's recommendation
- Irregularities of team activities
- Inadequate visibility of top management support

Unit Level

- Lack of management commitment
- Inability to change organizational culture
- Improper planning
- Lack of continuous education and training
- Incompatible organizational structure and isolated individuals and commitment
- Ineffective measurement techniques and lack of access to data and results
- Paying inadequate attention to internal and external customers
- Inadequate use of empowerment and teamwork
- Failure to continually improve

Middle Level Managers

- Sabotage / Lack of support from top management
- **Politics / turf battles
- **%Lack of resources**
- *Inadequate / Insufficient training
- *Employees lack of confidence in programme

Challenges

- Feedback from point of care staff around the world consistently highlights
 the difficulty that health systems face in establishing a safety culture that is
 based on blame-free reporting and in which learning is more powerful than
 judgment.
- Detailed multidisciplinary investigation, including expert inputs, in-depth interviews with those involved, and reconstruction of the events that occurred, is less commonly undertaken
- The process of achieving sustainable reductions in risk and improvements in patient safety seldom works well

Informed Culture

Those who manage and operate the systems have current knowledge about the factors that determine the safety of the system

Learning Culture

Willingness and know-how to draw the right conclusion from a safety information system and to implement reforms

Reporting Culture

Prepared to report their errors and near misses

Safety Culture

Just Culture

Encouraged and even rewarded for providing safety-related information, but must be clear about what is acceptable and unacceptable behavior

Open Culture

Staff feel comfortable discussing patient safety incidents and raising safety issues with both colleagues and senior managers