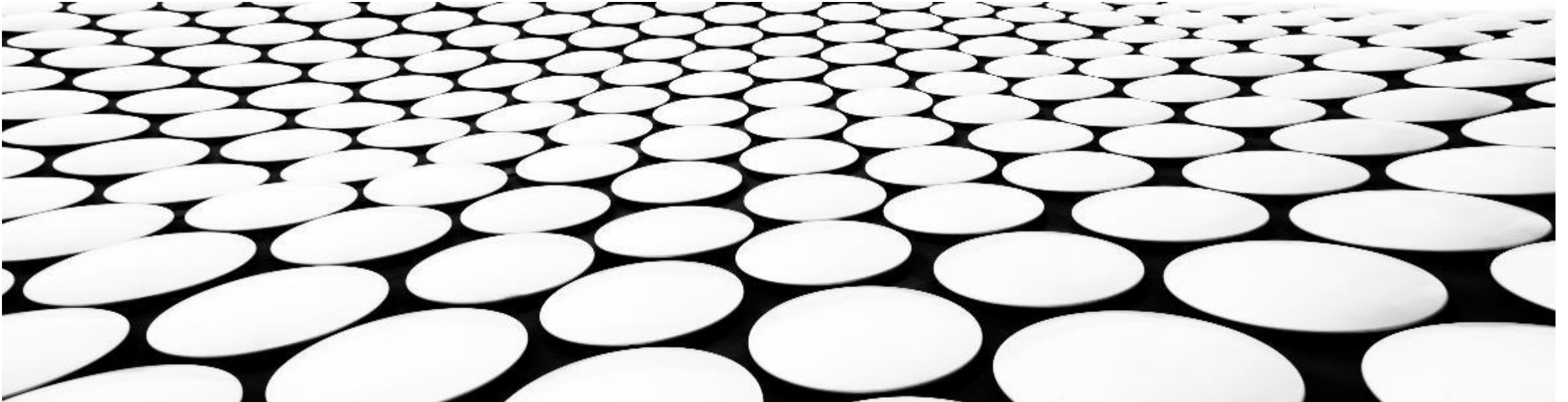

PATIENT SAFETY IN THE HEALTH CARE SYSTEM SRI LANKA

DR. S. SRIDHARAN

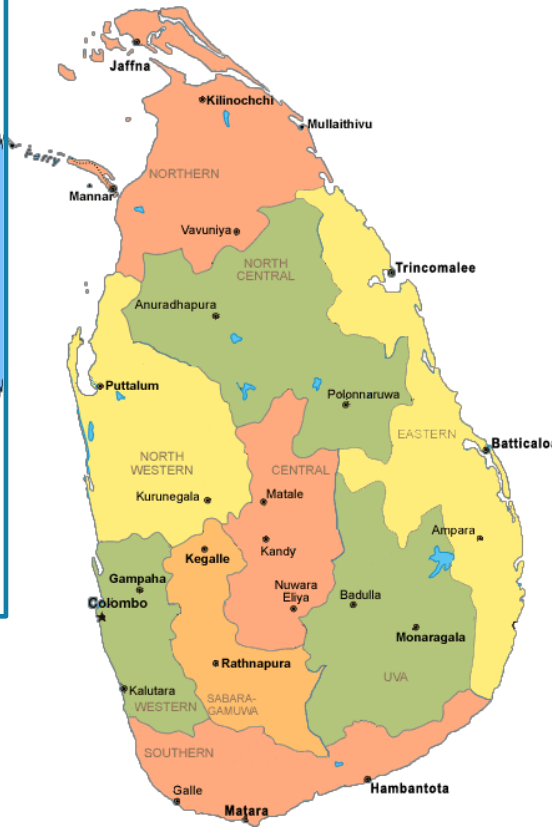
DEPUTY DIRECTOR GENERAL – PLANNING

MINISTRY OF HEALTH, SRI LANKA





Surface Area: 64, 630 sq.km



- Population: 22.1 million
- 9 Provinces
- 9 Devolved Health Regions with 26 RDHS
- Health Expenditure 3.8 % of GDP
- US \$ 1.82 billion – Budget Allocation (2019)
- Per Person Total Health Expenditure US\$ 119 (2017)

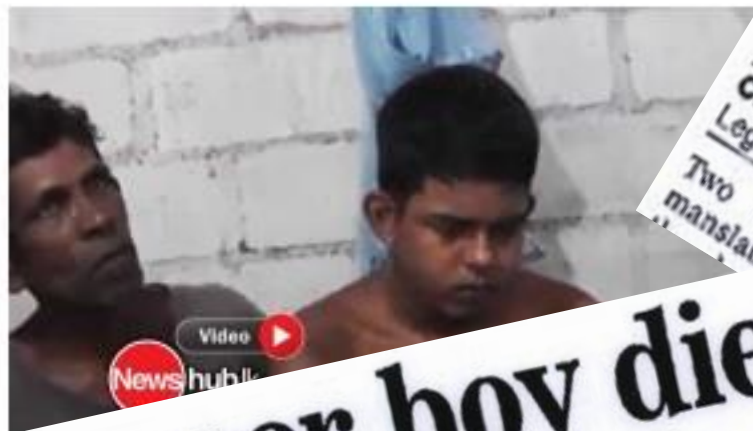
Literacy

- Total population: 92.6%
- Male: 93.6%
- Female: 91.7% (2015 est.)



16 year old student blinded due to consuming medicine dispensed by Hospital; Govt. says 'investigating' – (Video)

By Staff Writer - August 17, 2020 9:25 am



Teenager given wrong drug dies

Clare Dyer
Legal correspondent
Two doctors
manslaughtered

Doctors will make mistakes

But a failsafe system as the law

'Wrong' leukaemia jab Teenager who was mistakenly injected with an anti-cancer drug into his spine while being

Negligence led to amputation of Achala's hand

By Eye Sri Lanka Editor
© FEB 15, 2013

Can you trust your doctor?



The committee appointed by the Health Ministry to inquire into the amputation of the arm of Achala Priyadarshini in its report has found that negligence of the health staff had lead to the incident.

The left hand of law student was amputated after she was transferred to the Colombo National Hospital from the Matara hospital where she had been admitted with a bone fracture.

Achala Priyadarshini was admitted to the Matara Hospital with fracture injuries in her left hand, after falling down a flight of stairs.

comprising Health Services Division doctors was appointed to investigate the incident.

Cancer boy dies after blunder over injection Teenage patient dies after doctors' injection mistake

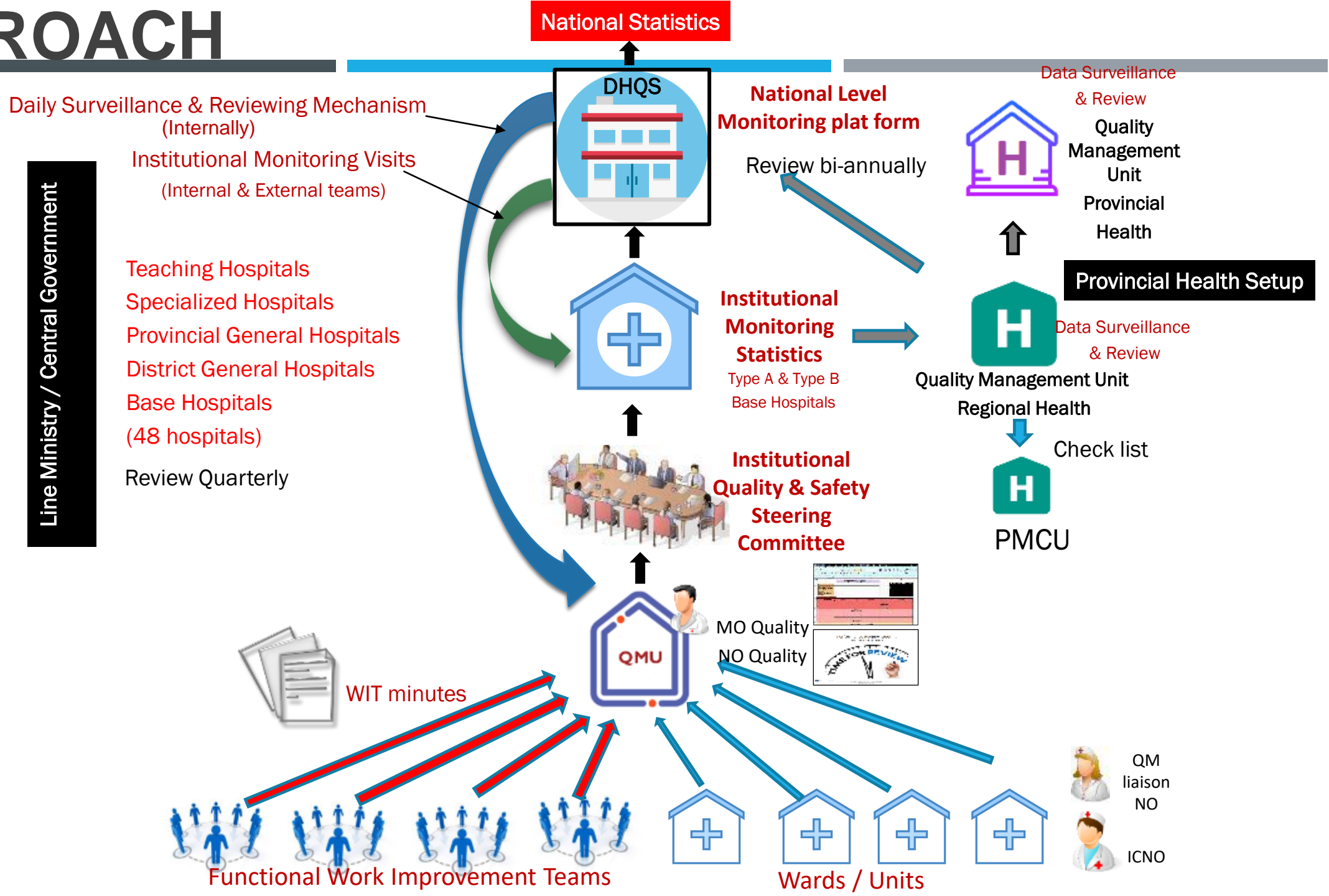
Drug mix-up killed leukaemia sufferer

Poor medical literacy causes errors in Sri Lanka

PURPOSE OF PATIENT SAFETY, REPORTING AND LEARNING SYSTEM

- Adverse Effects – highlighted in Mass Media
- Lessons learned from other countries
- Patient Complains
- Understanding the cost of poor quality
- To ensure safety and quality standards within the country

APPROACH



SITUATION ANALYSIS 2015

| Summary Dashboard | | | | | |
|-------------------|---|----------------|-----------------|------------|---------------------------------|
| Strate gy | Strategic Direction | Total Marks | Marks Scored | Assessment | Comments |
| 1 | Strategic Direction 1 | 39 | 21 | | Good but room to improve |
| 1.1 | Legal and Regulatory Framework | 24 | 10 | | Weak, need attention |
| 1.2 | Accreditation and External Quality Assessment | 9 | 5 | | Good but room to improve |
| 1.3 | Safety Culture at HCF | 3 | 3 | | Very Good, keep it up |
| 1.4 | Patient Involvements in PS and Care | 3 | 3 | | Very Good, keep it up |
| 2 | Strategic Direction 2 | 9 | 2 | | Need to commence |
| 2.1 | Adverse Events Monitoring | 9 | 2 | | Need to commence |
| 3 | Strategic Direction 3 | 24 | 8 | | Weak, need attention |
| 3.1 | Competent Workforce | 12 | 6 | | Good but room to improve |
| 3.2 | Patient Safety Risk Management | 12 | 2 | | Need to commence |
| 4 | Strategic Direction 4 | 33 | 25 | | Very Good, keep it up |
| 4.1 | Infection Prevention and Control | 24 | 18 | | Very Good, keep it up |
| 4.2 | Sterilized Equipment | 3 | 2 | | Good but room to improve |
| 4.3 | Environment, General Hygiene and Sanitation | 6 | 5 | | Very Good, keep it up |
| 5 | Strategic Direction 5 | 60 | 28 | | Weak, need attention |
| 5.1 | Safe Surgical Care | 6 | 3 | | Good but room to improve |
| 5.2 | Safe Childbirth | 6 | 4 | | Good but room to improve |
| 5.3 | Safe Injection | 12 | 8 | | Good but room to improve |
| 5.4 | Safe Medication | 3 | 3 | | Very Good, keep it up |
| 5.5 | Blood Safety | 3 | 2 | | Good but room to improve |
| 5.6 | Medical Devices Safety | 6 | 2 | | Weak, need attention |
| 5.7 | Safe Transplantation | 24 | 6 | | Weak, need attention |
| 6 | Strategic Direction 6 | 9 | 3 | | Weak, need attention |
| 6.1 | Research Capacity | 9 | 3 | | Weak, need attention |

CHALLENGES

- Develop mechanism for reporting all incidents and analyzing
- Frequent changes of Heads of Institutions
- Establishing a standardized system in all health institutions
- Training and development of health care workers for proper analysis of adverse incidents
- Litigation issues related to patient reporting system and develop a just culture
- Resistance to adopt and implement the PS RLS
- Organizational culture and related issues

OVERCOMING RESISTANCE



- Healthcare Quality and Safety Committee in Sri Lanka Medical Association
- Involvement of Professional Colleges, training schools and Postgraduate Institute of Medicine (PGIM)
- Creating Patient Safety Culture in Hospitals
- Monitoring with 23 clinical indicators
- Establishment of Quality Management Units in Hospitals
- Sharing best practices among the hospitals
- Starting of Postgraduate Diploma in Healthcare Quality and Safety
- Providing feedback and fix the system after reporting an adverse event

INTERVENTIONS



UNIVERSITY OF COLOMBO

SRI LANKA

This is to certify that

Sayakkara Mesthrilage Navoda Sandamali Maleesha Mallawarachchi

was awarded the

Postgraduate Diploma in Healthcare Quality and Patient Safety

on

1st June, 2018

at the

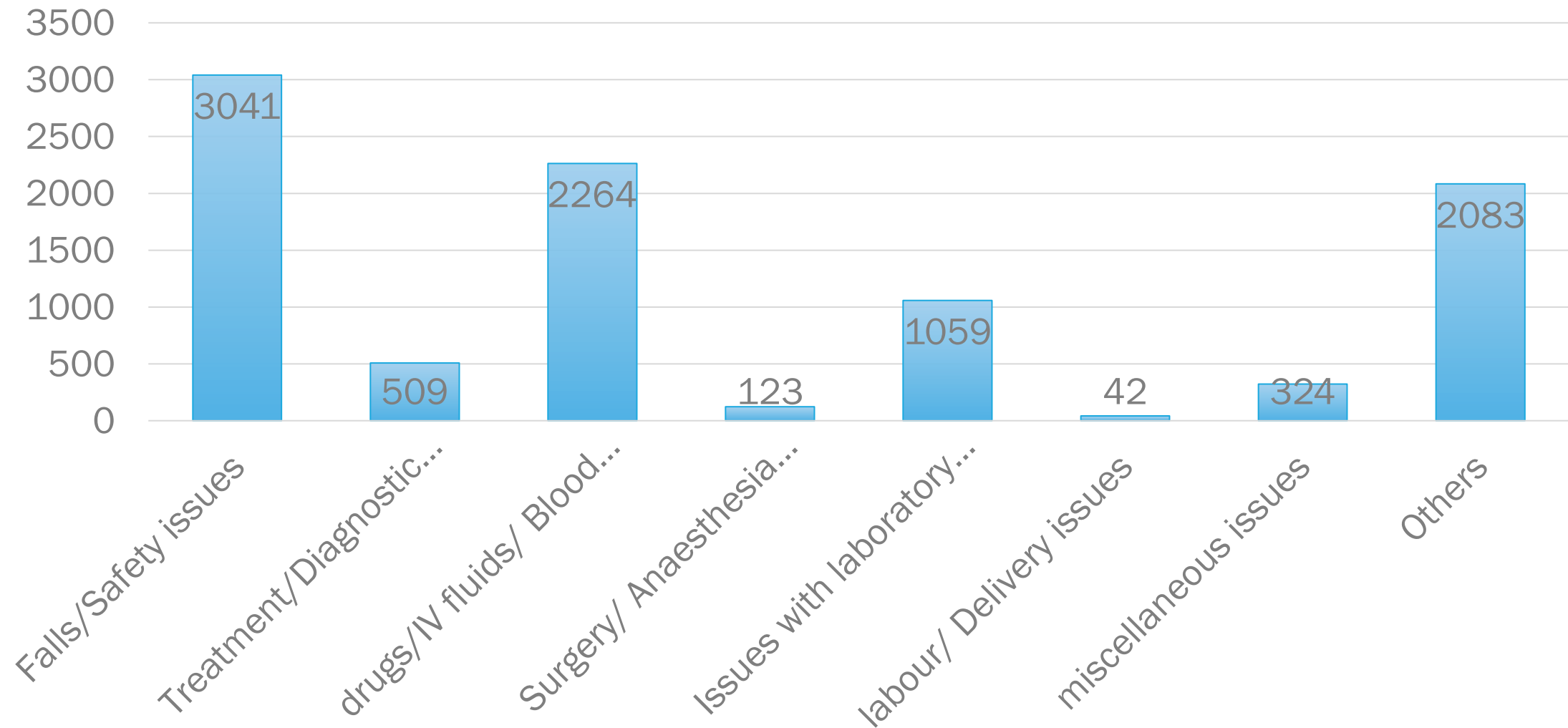
CONVOCATION

held in Colombo on the 12th day of November, 2018

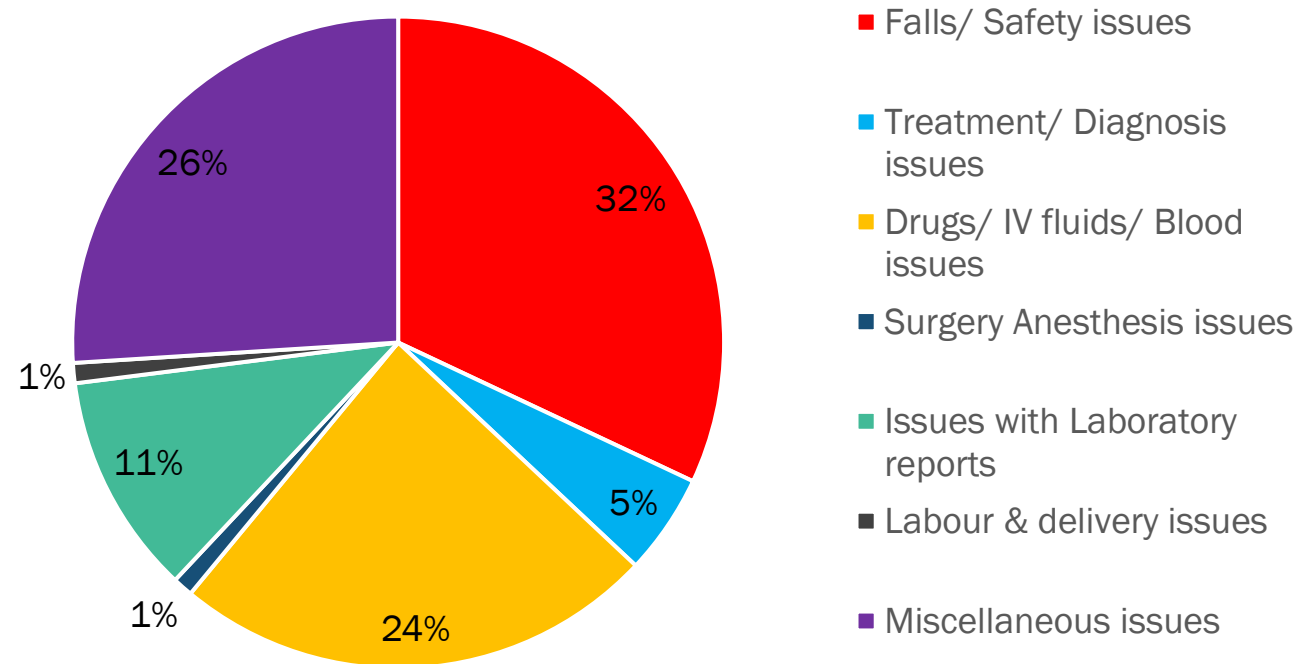
Witness our hands this Twelfth day of November in the year Two Thousand and Eighteen.

**POSTGRADUATE
DIPLOMA IN
HEALTHCARE
QUALITY AND
PATIENT
SAFETY**

TOTAL NUMBER OF ADVERSE EVENTS REPORTED FROM 43-LINE MINISTRY INSTITUTIONS IN 2019.

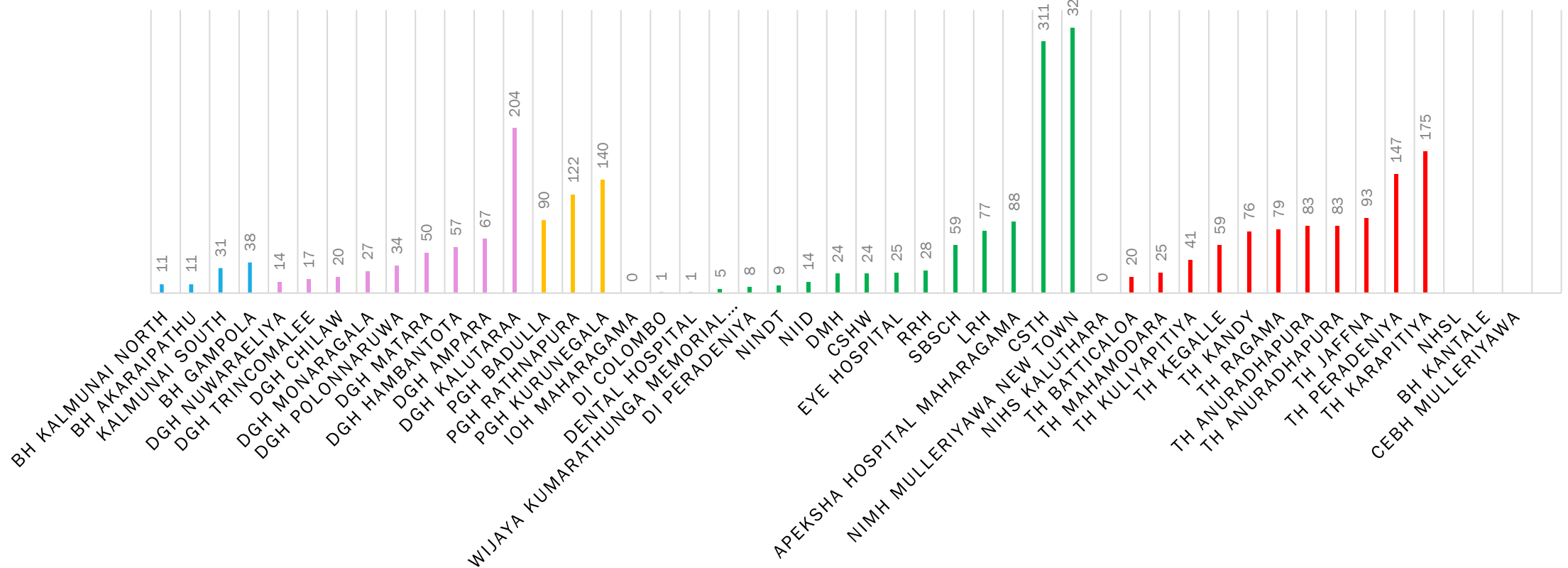


PERCENTAGE OF DIFFERENT TYPES OF ADVERSE EVENTS REPORTED FROM 43 LINE MINISTRY INSTITUTIONS IN 2019



NUMBER OF **PATIENT FALLS** REPORTED IN EACH LINE MINISTRY HOSPITAL IN 2019.

NUMBER OF PATIENT FALLS IN EACH HOSPITAL IN 2019



INDICATORS RELATED TO PATIENT SAFETY : LINE MINISTRY HOSPITALS

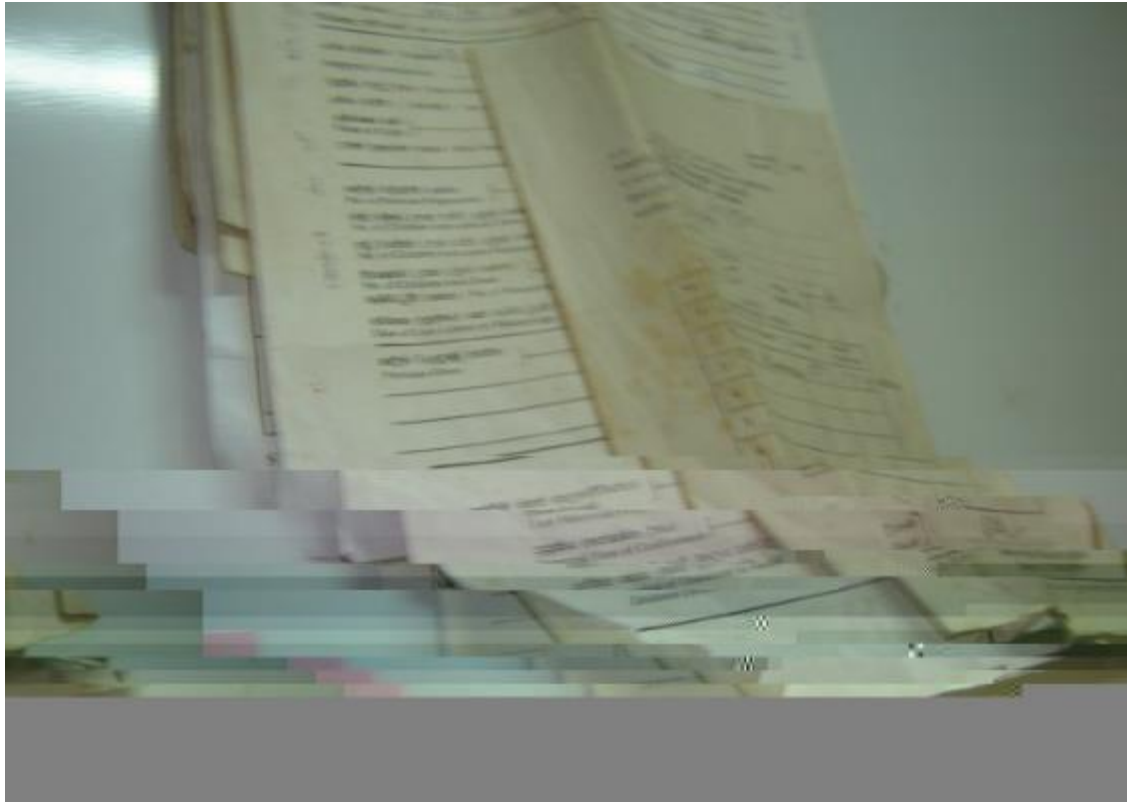
| Indicator | 2019 | 2020 |
|--|-------|--------|
| Percentage of patients given a fibrinolytic in <30 minutes of arrival in ST Elevation Myocardial Infarction(STEMI) | 52% | 53% |
| Rate of Postponement of Elective Surgery | 7.24% | 10.60% |
| Post Caesarean Surgical Site Infection Rate | 0.82% | 0.6% |
| MRSA bacteraemia rate | 2.5% | 3.3% |

WAY FORWARD

- Strategic Plan for Directorate of Healthcare Quality and Safety to be Finalized for 2021 – 2025
- Introducing Patient Safety in Primary care System Strengthening Project (PSSP)
- Establish National Accreditation System
- Programme to share Quality and Safety Best Practices
- Strengthen hospitals monitoring visits
- To overcome litigation issues related to patient reporting system and develop a just culture
- Deployment of check list to assess quality and safety in Primary Health Care Unit
- Finalizing of National Action Plan on Medication Safety
- The following guidelines have been developed and are in pipeline for finalization and publishing:
- National Guidelines on Management of Central Sterile Supplies Department
- National guidelines on Management of Hypertension
- Introducing digital health system

PATIENT RECORD

Before



After

[illegible]

ORGANIZATION OF WARDS

Before



After



OXYGEN STORAGE BEFORE & AFTER



PHARMACY

Before



After



PATIENT SAFETY RELATED EXCERPTS FROM THE DRAFT REVISION OF NATIONAL POLICY ON HEALTHCARE QUALITY AND SAFETY

KEY RESULT AREA 1: CUSTOMER / PATIENT SATISFACTION AND EXPERIENCE

OBJECTIVE:

To strengthen organizational settings towards customer-focused care responsive to their preferences, expectations and values and patient-centred care.

STRATEGIES

- Enhance patient centered care
- Develop mechanisms to ensure timeliness on service delivery
- Develop mechanisms to ensure responsiveness on service delivery for all including the disabled, elderly & special groups in hospitals
- Engage patients and community for improvement of health and service delivery
- Establish and enhance mechanisms for grievance handling

ICONIC LOTUS TOWER ILLUMINATED IN ORANGE TO MARK PATIENT SAFETY DAY 2021

