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
- Turnover and changes in key personnel
- 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.
Safety Culture

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

Reporting Culture
Prepared to report their errors and near misses.

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

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

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