PATIENT SAFETY IN THE HEALTH CARE SYSTEM
SRI LANKA

DR. S. SRIDHARAN
DEPUTY DIRECTOR GENERAL – PLANNING
MINISTRY OF HEALTH, SRI LANKA
Population: 22.1 million
9 Provinces
9 Devolved Health Regions with 26 RDHS

Surface Area: 64,630 sq.km

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)

Doctors will make mistakes

Teenager given wrong drug dies

‘Wrong’ drug in hospital

Negligence led to amputation of Achala’s hand

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**

**Wards / Units**

- Functional Work Improvement Teams

**Wards / Units**

- MO Quality
- NO Quality

**ICNO**

- Institutional Quality & Safety Steering Committee

**Institutional Monitoring Statistics**

- Type A & Type B Base Hospitals

**DMO**

- Review bi-annually

**National Level Monitoring platform**

**QM liaison NO**

**National Statistics**

**Data Surveillance & Review**

- Quality Management Unit Provincial Health

**Regional Health Quality Management Unit**

- PMCU

- Data Surveillance & Review

**Provincial Health Setup**

- Institutional Monitoring Visits (Internal & External teams)

**Daily Surveillance & Reviewing Mechanism** (Internally)

**Line Ministry / Central Government**

- Teaching Hospitals
- Specialized Hospitals
- Provincial General Hospitals
- District General Hospitals
- Base Hospitals (48 hospitals)

- Review Quarterly

**Provincial Health Setup**

- Data Surveillance & Review

- Institutional Monitoring Visits

- Type A & Type B Base Hospitals

- Institutional Quality & Safety Steering Committee

- Review bi-annually

- National Level Monitoring platform

- Wards / Units

- Functional Work Improvement Teams

- WIT minutes
<table>
<thead>
<tr>
<th>Strategy</th>
<th>Strategic Direction</th>
<th>Total Marks</th>
<th>Marks Scored</th>
<th>Assessment</th>
<th>Comments</th>
</tr>
</thead>
<tbody>
<tr>
<td>1</td>
<td>Strategic Direction 1</td>
<td>39</td>
<td>21</td>
<td></td>
<td></td>
</tr>
<tr>
<td>1.1</td>
<td>Legal and Regulatory Framework</td>
<td>24</td>
<td>10</td>
<td></td>
<td></td>
</tr>
<tr>
<td>1.2</td>
<td>Accreditation and External Quality</td>
<td>9</td>
<td>5</td>
<td></td>
<td></td>
</tr>
<tr>
<td>1.3</td>
<td>Assessment</td>
<td>9</td>
<td>5</td>
<td></td>
<td></td>
</tr>
<tr>
<td>1.4</td>
<td>Safety Culture at HCF</td>
<td>3</td>
<td>3</td>
<td></td>
<td></td>
</tr>
<tr>
<td>1.5</td>
<td>Patient Involvements in PS and Care</td>
<td>3</td>
<td>3</td>
<td></td>
<td></td>
</tr>
<tr>
<td>2</td>
<td>Strategic Direction 2</td>
<td>9</td>
<td>2</td>
<td></td>
<td></td>
</tr>
<tr>
<td>2.1</td>
<td>Adverse Events Monitoring</td>
<td>9</td>
<td>2</td>
<td></td>
<td></td>
</tr>
<tr>
<td>3</td>
<td>Strategic Direction 3</td>
<td>24</td>
<td>8</td>
<td></td>
<td></td>
</tr>
<tr>
<td>3.1</td>
<td>Competent Workforce</td>
<td>12</td>
<td>6</td>
<td></td>
<td></td>
</tr>
<tr>
<td>3.2</td>
<td>Patient Safety Risk Management</td>
<td>12</td>
<td>2</td>
<td></td>
<td></td>
</tr>
<tr>
<td>4</td>
<td>Strategic Direction 4</td>
<td>33</td>
<td>25</td>
<td></td>
<td></td>
</tr>
<tr>
<td>4.1</td>
<td>Infection Prevention and Control</td>
<td>24</td>
<td>18</td>
<td></td>
<td></td>
</tr>
<tr>
<td>4.2</td>
<td>Sterilized Equipment</td>
<td>3</td>
<td>2</td>
<td></td>
<td></td>
</tr>
<tr>
<td>4.3</td>
<td>Environment, General Hygiene and Sanitation</td>
<td>6</td>
<td>5</td>
<td></td>
<td></td>
</tr>
<tr>
<td>5</td>
<td>Strategic Direction 5</td>
<td>60</td>
<td>28</td>
<td></td>
<td></td>
</tr>
<tr>
<td>5.1</td>
<td>Safe Surgical Care</td>
<td>6</td>
<td>3</td>
<td></td>
<td></td>
</tr>
<tr>
<td>5.2</td>
<td>Safe Childbirth</td>
<td>6</td>
<td>4</td>
<td></td>
<td></td>
</tr>
<tr>
<td>5.3</td>
<td>Safe Injection</td>
<td>12</td>
<td>8</td>
<td></td>
<td></td>
</tr>
<tr>
<td>5.4</td>
<td>Safe Medication</td>
<td>3</td>
<td>3</td>
<td></td>
<td></td>
</tr>
<tr>
<td>5.5</td>
<td>Blood Safety</td>
<td>3</td>
<td>2</td>
<td></td>
<td></td>
</tr>
<tr>
<td>5.6</td>
<td>Medical Devices Safety</td>
<td>6</td>
<td>2</td>
<td></td>
<td></td>
</tr>
<tr>
<td>5.7</td>
<td>Safe Transplantation</td>
<td>24</td>
<td>6</td>
<td></td>
<td></td>
</tr>
<tr>
<td>6</td>
<td>Strategic Direction 6</td>
<td>9</td>
<td>3</td>
<td></td>
<td></td>
</tr>
<tr>
<td>6.1</td>
<td>Research Capacity</td>
<td>9</td>
<td>3</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>
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
UNIVERSITY OF COLOMBO

SRI LANKA

This is to certify that
Sayakkara Muthirijage Navoda Sandamali Malvika 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.
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

- Falls/ Safety issues: 32%
- Treatment/ Diagnosis issues: 26%
- Drugs/ IV fluids/ Blood issues: 11%
- Surgery Anesthesia issues: 5%
- Issues with Laboratory reports: 1%
- Labour & delivery issues: 1%
- Miscellaneous issues: 24%
NUMBER OF PATIENT FALLS REPORTED IN EACH LINE MINISTRY HOSPITAL IN 2019.
## Indicators Related to Patient Safety: Line Ministry Hospitals

<table>
<thead>
<tr>
<th>Indicator</th>
<th>2019</th>
<th>2020</th>
</tr>
</thead>
<tbody>
<tr>
<td>Percentage of patients given a fibrinolytic in &lt;30 minutes of arrival in ST Elevation Myocardial Infarction (STEMI)</td>
<td>52%</td>
<td>53%</td>
</tr>
<tr>
<td>Rate of Postponement of Elective Surgery</td>
<td>7.24%</td>
<td>10.60%</td>
</tr>
<tr>
<td>Post Caesarean Surgical Site Infection Rate</td>
<td>0.82%</td>
<td>0.6%</td>
</tr>
<tr>
<td>MRSA bacteraemia rate</td>
<td>2.5%</td>
<td>3.3%</td>
</tr>
</tbody>
</table>
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
ORGANIZATION OF WARDS

Before

After
OXYGEN STORAGE BEFORE & AFTER
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