Report on the

Regional consultation on improving quality of care and patient safety in the Eastern Mediterranean Region

Jeddah, Saudi Arabia
9–11 June 2014

World Health Organization
Regional Office for the Eastern Mediterranean

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EXECUTIVE SUMMARY

An expert consultation on health care quality and safety improvement was held on 9–11 June 2014 in Jeddah, Saudi Arabia. It was organized by the WHO Regional Office for the Eastern Mediterranean in collaboration with the Saudi Central Board of Accreditation for Health care Institutions (CBAHI) and was attended by health care representatives of Member States, international experts on accreditation, quality and clinical governance in health care. The main objectives of the consultation were to:

- present the current status of quality of care and patient safety in Region and the challenges and gaps in information
- review ongoing initiatives and programmes for safety and quality
- share the different approaches to improve the quality of health care with focus on accreditation, quality assurance and clinical governance
- develop a regional strategy and roadmap that can help improve the quality of care in countries of the Region.

The programme of the three-day consultation was organized into technical sessions on quality improvement in health care, patient safety, accreditation in health care and patient safety research.

During the consultation, international and regional experts discussed the general concepts related to patient safety, quality and various approaches to evaluate and improve them. The status of patient safety research and areas to be focused in research were highlighted. Detailed analysis of the current situation of patient safety and quality in the Region, the challenges and measures taken so far were also dealt with comprehensively. The challenges to patient safety in different groups of countries and proposals to overcome them were also discussed during group work sessions.

Regarding the current situation of patient safety in the Region, there is a high burden of unsafe care and poor compliance with even the minimal levels of safety in health care. The main challenges to safety and quality include the high burden of communicable diseases, unsafe childbirth and poor access to health care, insufficent policies and legislation in patient safety and poor sustainablity of the existing initiatives. There is a need for trained workforce in patient safety and quality. Research in patient safety is almost not yet seen as a priority strategy to promote safer care.

There lack of national policies, skilled human resource, and poor culture for patient safety at the institutional level are impede patient safety improvement in the Region. There is a poor sustainability of the patient safety initiatives. Patient safety research is negligible and primary health care services are not utilized to their full potential. In some countries there are additional challenges due to communicable disease, overburdened health systems, resource limitation and the migration of trained workforce.

During the consultation, a focus was made on the concept of clinical governance and its role to support the quality and safety of health care interventions at the health system levels.

It represents a framework by which organizations continuously improve the quality of their services and maintain high standards of care by creating an environment in which excellence in clinical care will flourish. The clinical governance approach is not yet well understood in the Region except in the Islamic Republic of Iran where some progress has been made. Essentially, clinical governance is an internal approach, relying on a culture of professional self-regulation

Considering the importance of well organized, primary health care setups, programmes for safety and quality for primary health care need to be organized so as to have a quality primary health care service that serves as a hub of coordination with diagnostic services, specialized care, hospitals, nongovernmental organizations and prevention services. Research in patient safety is essential to estimate the exact burden of unsafe care, to identify solutions and improve the safety and quality of health care.

The consultation concluded with agreement on the following actions as a roadmap for improving quality of care and patient safety in countries.

1. Build on the previous efforts by the patient safety friendly hospital initiative.
2. Conduct another mapping of the status of health care accreditation in the Region.
3. Promote clinical governance as a complementary approach to strengthening quality and safety.
4. Raise the issue of quality and safety at the policy level in countries.
5. Undertake research in the area of quality and safety.
6. Intensify efforts to establish networks on quality and safety.

1. INTRODUCTION

An expert consultation on health care quality and safety improvement was held on 9–11 June 2014 in Jeddah, Saudi Arabia. It was organized by the WHO Regional Office for the Eastern Mediterranean in collaboration with the Central Board of Accreditation for Health care Institutions (CBAHI) in order to provide an opportunity to broaden the scope of initiatives to cover health care quality at all levels of care, and to establish a roadmap and action plan for improving quality and safety in countries. It was attended by health care representatives of Member States and international experts on accreditation, quality and clinical governance in health care.

The meeting objectives were to:

- present the current status of quality and safety of health care in countries of the Eastern Mediterranean, including the existing challenges and gaps in information;
- review and update the various initiatives and programmes being undertaken to improve quality and safety in countries of the Region;
- share the different approaches to improve the quality of health care with focus on accreditation, quality assurance and clinical governance; and
- develop a regional strategy and roadmap that can help improve the quality of care in countries.

The consultation was inaugurated by HE Mr Adel Fakeih, Acting Minister of Health and Minister of Labour, Saudi Arabia, who highlighted the new challenges and revolutionary changes faced by health care in Saudi Arabic due to the increasing population and economic growth. He noted that the Ministry of Health had made it mandatory for all health care services to be accredited by the CBAHI.

In his welcome note Dr Salem Al Wahabi, Director General, CBAHI, who expressed his pleasure at the initiation of partnership with WHO, and resolved to make all efforts to ensure its success. He emphasized that traditionally, innovation in health care had focused on devices and medications and that it was time to apply the same ingenuity and innovative thinking in human factors to improving patient safety and the quality of health care.

Dr Sameen Siddiqi, Director Health System Development, WHO Regional Office for the Eastern Mediterranean, delivered a message from Dr Ala Alwan, WHO Regional Director for the Eastern Mediterranean. In his message the Regional Director referred to the commitment expressed by countries of the Region to moving towards universal health coverage, which envisaged access to essential health services of sufficient quality to all people of the Region.

Quality and safety in health care remained a challenge, he noted. The consultation was intended to provide an opportunity to set a direction for improving the standards of quality and safety in health care suitable to each country. In this context the regional Patient Safety Friendly Hospital Initiative had been helpful in enhancing the visibility and implementation

of patient safety practices in health care setups of the Region. However, the initiative was not yet being fully implemented in many countries. He expressed the hope that the consultation would prove to be a step towards commitment to quality and safety in health care through collaboration and partnership. He commended the efforts that went into organizing the consultation and expressed his appreciation for the excellent support provided by the Central Board for Accreditation of Health Care Institutions in Saudi Arabia.

The programme of the consultation comprised technical sessions dedicated to quality improvement in health care, patient safety, accreditation and research in patient safety. This document is a report of the consultation process and the proceedings along with the next steps agreed upon by the participants and experts for improving health care quality and safety in countries.

2. QUALITY IMPROVEMENT IN HEALTH CARE

2.1 Updates on quality improvement approaches in health care

Dr Charles Shaw, WHO Temporary Adviser, presented a conceptual outline of the quality cycle and various technical and behavioural factors influencing it. He also highlighted that quality improvement interventions and programmes should work within a framework defining policy, organization, methods and available resources. Any programme for quality must have a balanced interplay between technical and behavioural factors.

Technical factors include research in biomedical and health services, technology assessment, framing clinical guidelines, care pathways and protocols. Behavioural factors that have a strong impact on the quality include governance and leadership, incentives, regulation in medicines, devices, equipment or provider regulation, inspection of the organisation and systems, teamwork, feedback, training and evaluation.

The discussion highlighted that the environment for quality is still not fully developed in the Region. Since there is considerable diversity in health services within the Region a single quality safety project may not be applicable to all countries. Sustainability of the patient safety/quality measures is a challenge. There is a need overcome the resistance against quality/patient safety initiatives, mainly observed among doctors, to identify causes and allay anxiety.

In addition, there is a need for capacity building and research on quality, education and training, rational use of health technology, institutionalizing the quality. There should be systems to make recommendations and to motivate the policy-makers. In this regard, incentives, e.g. financial, should be considered. There is need to identify the gap between the patient's expectation and the performance of health care delivery systems. The role of WHO can be more proactive at the organizational level.

2.2 Health care quality and patient safety in countries of the Gulf Cooperation Council: current situation and perspectives

The presentation and discussion underscored the need for taking proactive steps in order to ensure the delivery of high quality and safe services:

- Creating regulatory bodies that should define comprehensive operational quality and facility standards
- Improving efficiency of IT utilization in health care delivery
- Increasing the involvement of community members in planning and development projects
- Creating strategic plans to deal with the increasing prevalence of chronic illnesses.

The strategies for quality and patient safety in GCC countries were presented as well as references to important resolutions and pledges in this context. All countries of the GCC have a national plan to improve and ensure quality in health care. All except Yemen have set up and are implementing GCC indicators for health care quality and are in the process of developing of standards, training workers and conducting studies to assess client satisfaction in quality. Saudi Arabia has made considerable achievement in building national capacity and accreditation of the health care facilities.

3. PATIENT SAFETY

3.1 WHO patient safety programme

WHO's patient safety programme has been established along a strategy aimed at strengthening health services worldwide. The key areas of work of the programme focus on the following areas.

- Strengthening services organization and clinical interventions such as: blood and transfusion safety; emergency and essential surgical care, integrated people-centred care; measurement and monitoring; primary care systems; regulation and accreditation; and transplantation.
- Developing strategies for patient safety and quality improvement: global safety partnerships; injection safety; safety and quality checklists; patient and family engagement; patients for patient safety; infection prevention and control; patient safety and quality education and training.
- Strengthening traditional and complementary medicine to strengthen the safety, quality, effectiveness of guidelines and knowledge and also hosting special projects such as the new injection safety campaign, or the new initiatives around genomics.

At present WHO is working on a global report on safety and quality. This will provide a global snapshot of safety and quality of health care services and provide a framework for improvement in the context of universal health coverage. It will be an attempt to collate international data and to highlight lack of data in certain areas.

3.2 Updates on the regional patient safety interventions

Patient safety interventions under way in the Region include the following.

- The "Save lives: clean your hands" initiative encourages countries to register through the WHO website to show their commitment to address hospital-acquired infections, use WHO hand hygiene framework for assessment of hospital-acquired infection and implement guidelines to prevent and reduce the incidence of hospital-acquired infections.
- The second initiative, "Safe surgery saves lives", aims to reduce the incidence of adverse events in surgery by compliance with specific standards and implementation of the WHO safe surgery checklist.
- The Patient Safety Friendly Hospital Initiative aims at introducing a culture of patient safety as a comprehensive programme that addresses key patient safety domains, such as leadership and management, evidence-based practices, patient and family involvement, environmental safety and lifelong learning. This initiative includes 140 standards that are classified as critical, core or developmental. An updated version is now available and being is expanded throughout the Region.
- A patient safety improvement toolkit has been finalized; it consists of a set of tools (solutions) that would help local teams to address patient safety gaps at the institutional level. It includes solutions in the fields of hospital-acquired infections, safe surgery, medication safety, inculcating a patient safety culture and reporting systems.
- The WHO multi-professional patient safety curriculum guide is being implemented by some health related universities in the Region, the childbirth checklist is in the pilot test phase of a clinical trial in a number of health care facilities across the Region.

3.3 Country experiences on patient safety programmes

Patient safety focal points presented the ongoing progress with the implementation of patient safety interventions in their respective countries as well as the perceived challenges and priorities. They also discussed the challenges that face patient safety improvement, the required actions and the support needed from WHO to ensure better progress with patient safety interventions. These are presented in Table 1.

Table 1. Summary of participants' feedback on challenges and needed actions to improve quality and safety for the three groups of countries

	Group 1 countries	Group 2 countries	Group 3 countries
Main challenges	The sustainability of the measures already in progress The lack of expertise in various areas of quality and safety The lack of coordination of primary health care services and improvement of the quality and patient safety in primary health	Lack of national policies and legislation due to political instability and financial limitations Organization management issues due to centralization of all services and inadequate training on safety There is lack of information systems automation and limited number of skilled	External and internal instability, civil wars, low priority for health care and quality and patient safety Primary health care: immunization, childhood diseases, unsafe childbirth, access to health care facilities Secondary and tertiary health care setups: overburdened beyond capacity .limited resources, lack of trained work force

	care	human resources	Attitude: patient safety/quality perceived as luxury not necessity
	The low capacities for research and training on patient safety	At the institutional level there is insufficient quality and safety culture with no incident reporting system	Resistance to change
		No revalidation of licenses for health care facilities and professionals	
Required action	Ensure stronger leadership and governance capacities for quality and safety improvement programmes	Adapt a framework for quality needs and plan with strong political commitment	Data to assess the magnitude of the problem.
		Budget allocation for accreditation programme: capacity building and provision of needed resources	Standardization and successful implementation of priority programmes
		Engaging the civil society and use of universal health coverage in advocacy for quality improvement	System for referral
			improvement of the infrastructure
		Improve communication among stakeholders	Involvement of the top leadership, ministers of health
			Training programmes workshops aiming to achieve a behavioural change that aims to introduce a culture of quality and safety improvement
			Availability of data on quality and patient safety and a response system
			Adopt existing standards and set targets realistic within a defined timeframe
How to ensure sustainability	Partnership with nongovernmental organizations and community involvement	Availability of a national plan for institutionalization of quality, enforcement of laws and regulations, provision of incentives related to performance	Clear vision, insight and commitment of the leadership
	Continuous engagement for quality and safety from health care professionals and professional associations	Involvement of the media and civil society	Directorate/departments dedicated to patient safety/quality training
			Regulations
		Engagement of health care professionals	Policy
			Audits
			Accountability
WHO support	Assisting in capacity building and research	Assistance in gap identification and analysis	Technical support
	Build partnership with training and education institutions	Advocacy and decision-makers buy-in	Advocacy at the ministerial level
		Activation of projects like PATH, PSFHI, etc.	Seminars, workshops for leadership
			Pledges, commitments
		Networking for benchmarking	

Important lessons learnt from the patient safety and quality activities are that organizations improve when there is leadership support and staff are motivated to achieve accreditation. The accreditation and safety could not be extended in most of the public organizations due to financial and other infrastructure problems. Political instability in a country delays the progress of quality, safety and accreditation.

4.   ACCREDITATION IN HEALTH CARE

4.1   Review of evidence and the value of accreditation

The process of accreditation involves a complex combination of organizational interventions. Although the evidence base for accreditation is relatively weak, it is stronger and better researched than for certification or licensing. There is almost no comparable evidence for certification or licensing of health care institutions, and little collaboration between accreditation, ISO certification and health care regulators to fill large gaps in the understanding the role of external evaluation in the governance of health systems.

There is evidence that preparation for accreditation is associated with increasing compliance with the organizational standards, and that the use of clinical guidelines, indicators and audit increases – but no evidence so far that the clinical outcomes improve.

The presentation underlined that accreditation is one tool available to a national programme for improving quality and safety; it is not a comprehensive programme in itself. There is a need to define the shared values of stakeholders e.g. government, professions, public, purchasers and managers; then a framework can be constructed of the various approaches which exist already, or may need to be introduced.

The discussion underscored the need for a clearly addressed situation analysis that would support the selection of accreditation as the mainstream quality strategy, based on a systematic review of the values, stakeholders and dimensions of quality, of existing and alternative mechanisms for quality regulation or improvement, or of related elements of health care reform in the country.

4.2   ISQua's International Accreditation Programme

Several countries have set up a national programme without this preparation and have then found unexpected delays and conflicts later on. These include the unclear scope and purpose of accreditation programme: there should be a clear definition of the main objectives for the quality improvement in the health care system (e.g. public accountability, protection of patients and staff, equity of service standards, promotion of patients' rights, adoption of evidence-based clinical practice, reduction of waste and inefficiency, professional self-regulation and improvement of performance of individuals, organizations and the overall health care system).

Other potential problems include possible gaps and overlaps of standards and regulatory mechanisms (e.g. professional development and licensing, institutional regulation and inspection) and the fragmentation of health reform initiatives (e.g. decentralization of control, empowerment of managers, health care financing and performance management, development of primary care and preventive services). As a result, donor agencies and successor governments may not be convinced that the decision to pursue accreditation was soundly based or worthy of further support

Member States should be advised to take stock of their existing quality systems before choosing to adopt new long-term strategies for improvement. The ISQua toolkit as guidance in selecting and developing appropriate technologies for external assessment could be adopted and WHO can facilitate the dissemination and exchange at the regional level of available tools which have been developed addressing transversal issues relevant for the successful implementation of quality and safety programmes.

ISQua's International Accreditation Programme (IAP) is the leading international health care external evaluation programme of its kind. It accredits the accreditors and so far 41 organizations in 30 countries have undergone IAP accreditation. Of these, three are from the Eastern Mediterranean Region.

Since 2010, ISQua has introduced a key strategic priority of growing its engagement with low and middle income countries. A strategic review was conducted in the Academia Nacional de Medicina, México. This review has resulted in initiatives such as:

- Annual scholarships/fellowship to attend its international conference and, where possible, provide mentorship and advisory programmes by ISQua experts
- Providing patient partners and accreditation framework for external evaluation
- Support and involvement in the WHO Patient Safety Friendly Hospital Initiative.

The 2012 ISQua Conference had a special emphasis on transitional countries, and in 2013 ISQua hosted its first regional meeting in Accra, Ghana.

4.3   Regional mapping of accreditation programmes

In 2009–2010, the Regional Office conducted a survey to map the health care accreditation intiatives in the Region. The specific objectives of the survey were to:

- Update the status of accreditation in terms of planning, design, implementation of the programme, development of standards, and health facilities under the programme
- Identify different stakeholders in accreditation at national, regional and international level who can assist or resist institutionalization of accreditation programmes in the Region
- Undertake an analysis of the strengths and limitations of the health care accreditation initiatives in different countries
- Clarify opportunities and challenges for further developing the programme in the Region.

Accreditation policy was found in 11 out of 18 countries. An accreditation programme is a part of the national reform plan in ten countries. Nine countries have developed recognized national standards. Seven countries have standards for primary health care centres, five have standards for ambulatory care and four have standards for laboratory.

Seven countries have a national accrediting body. Hospitals are joining the programme in all countries that have accreditation policy. Primary health care centres are a part of the

accreditation programme in six countries and ambulatory care and laboratories are included in only three countries. Seven countries reported that they have trained mix skill national surveyors. The accreditation is mandatory in four and voluntary in seven countries.

The major stakeholders are ministries of health, accrediting bodies, health facilities including the private sector, politicians and parliament, syndicates, medical associates insurance and ministry of finance. Most of stakeholders are supportive and of these the Ministry of Health is the most influential. There was some resistance to accreditation programme in the private sector and medical associates.

Three international accreditation bodies are operating in the Region. One of these bodies has accredited 179 health care organizations until October 2013.

The survey highlighted that accreditation is being used increasingly as a tool for government regulation to guarantee quality of care in the Region. There are wide variations in the level of development and progress of accreditation programme in countries of the Region. It is important to update this map every two to three years.

4.4 Country experiences in accreditation

The mission of CBAHI in Saudi Arabia is to promote quality and safety by supporting health care facilities to continuously comply with accreditation standards. The main areas of activity for CBAHI are preparation, accreditation and monitoring. There is a well-developed organizational set-up with dedicated departments for quality, accreditation and research in addition to the administrative departments.

The Saudi accreditation programme is mandatory and is linked to the licensure. It includes certification programmes in blood transfusion and radiation safety. The impact of accreditation is assessed by the views of government, patients and providers.

The Health Care Accreditation Council (HCAC) in Jordan has evolved into a centre of expertise on quality improvement systems and patient safety tools and provides a diverse range of services in response to the market needs.

There are two main areas of activity.

• Surveys and Standards Development Department, which concentrates on development of standards and training of the surveyors, mock surveys and accreditation.
• Education and Consultation Department, which provides consultation to the government, preparedness, training certificate courses and consultant.

HCAC has developed seven different sets of standards. These include standards for accreditation/certification of hospitals, primary health care, medical transport services, breast imaging units, diabetes care, cardiac care and family planning and reproductive health centres.

HCAC has the capability to respond to national and regional needs by providing consultation, education and development of human resource and accreditation.

In the course of interactions through evaluations and assessments, HCAC has observed that the commitment of physicians facilitates the accreditation process. Staff may perceive that accreditation is extra work for which they are not rewarded and over-eager managers can make the entire accreditation process feel punitive and intrusive rather than motivating.

The number of certified professionals in quality is eight consultants, 35 quality professionals, 27 infection control, 14 risk management and 26 in leadership and management field. 17 hospitals and 90 primary health care centres have been accredited.

The future focus is to develop data and research, work with government on their policies, engage in national efforts for medical tourism and raise the level of awareness of the public and the professionals.

The accreditation system of the Council of Health Service Accreditation of South Africa (COHSASA) is based on the principle of multidisciplinary health service provision. In this system, each department or service in a health care establishment forms a dependent subsystem of the whole and functions through the utilization of tested policies and procedures congruent with those of other services and departments. The implementation of the programme requires all sections of the organization to achieve compliance with multidisciplinary standards. The aim is the production of coordinated quality patient care and resource utilization. The programme incorporates a web-based information system that provides continuous access to compliance with the standards and enables management to make informed decisions.

The feedback and discussion underscored that for participants, it is important to decide whether accreditation should be voluntary or mandatory. It should preferably be done in real time and not as a planned activity. It was suggested that the accreditation process may be modified to take different approaches example disease specific standards, expertise in specific domains like leadership, clinical practice, setting targets with time frame. Other countries of the Region should use lessons from the experience of CBAHI in Saudi Arabia and HCAC in Jordan. ISQua should consider the accreditation of regulatory bodies; accreditation should be independent of the Ministry of Health.

The role of the directorates of quality in ministries of health should be reviewed with the aim of universal health coverage with focus on primary health care and to generate data specific to primary health care. There was a strong recommendation for the adoption of clinical governance as an overarching system to improve quality in health care.

4.5 Group work

For the group work, participants were divided according to country group. Group 1 comprises countries where socioeconomic and health development has progressed

considerably over the past decades (Bahrain, Kuwait, Oman, Qatar, Saudi Arabia and United Arab Emirates) Group 2 comprises largely middle-income countries that have developed extensive public health infrastructure but face resource constraints (Egypt, Islamic Republic of Iran, Iraq, Jordan, Lebanon, Libya, Morocco, occupied Palestinian territory, Syria and Tunisia). Group 3 comprises countries that face constraints in improving population health outcomes as a result of lack of resources, political instability and other complex development challenges (Afghanistan, Djibouti, Pakistan, Somalia, Sudan and Yemen)

For group1 countries, the main challenges identified were the lack of sustainability of the measures already in progress and the insufficient expertise in various areas of quality and safety. There is poor coordination of primary health care services with the other stakeholders and a need for improvement in quality and patient safety in primary health care. Research and training in patient safety needs to be developed. WHO can support by assisting in capacity building and developing in research and patient safety. The group proposed partnership with ISQua for education in patient safety.

For group 2 countries, participants reported that the national policies and legislation on patient safety are not developed. Due to centralization of all services and inadequate training on safety there are issues in organization management such as the lack of information systems automation and the limited number of skilled human resources. At the institutional level there is insufficient culture on quality of care and patient safety along with the absence of incident reporting systems. In addition, there is no revalidation of licenses for health care organizations and professionals. The actions needed to address challenges include adapting a framework for quality with strong political commitment. There should be dedicated budget for accreditation programme, capacity building and provision of needed resources. There is also a need to engaging the civil society and using of universal health coverage in advocacy for promoting quality improvement interventions.

To ensure the sustainability of these measures, there should be a national plan for the institutionalization of quality, the enforcement of laws and regulations, and the provision of incentives for better performance. The involvement of media and civil society and the engagement of health care professionals in health care quality and patient safety would assist in sustaining the efforts.

WHO can support by providing assistance in gap identification and analysis, advocacy and decision makers buy-in, activation of projects like the Performance Assessment Tool for Hospitals (PATH), PSFHI and networking for benchmarking.

For group 3 countries, participants reported that there is poor implementation of immunization programmes, unsafe childbirth and poor access to health care facilities at the level of primary health care. The secondary and tertiary health care setups are overburdened due to limited resources and lack of trained workforce.

WHO can support by providing technical support, advocacy at the ministerial level, assisting in conducting seminars and workshops for leadership and getting pledges, commitments for ensuring safety and quality in health care.

There was a general agreement that, in addition to the lack of resources, there is weak commitment of the leadership to patient safety in most countries of the Region. Media and civil society representatives could play a positive role in raising awareness, giving feedback and sustaining patient safety in health care.

WHO support to the policy-makers in the three groups should be tailored according to the requirement of the countries for example supporting research in group 1, 2, and training in group 3. The results can influence the policy-makers to focus on closely related issues like immunization, diarrheal diseases and water sanitation under one programme. Research with simple tools adapted to the particular set up should be encouraged. WHO should maintain its role as counseling and collaborating body. Although most of the contact and collaborative work is done with ministries of health, WHO must take the opportunity to work with other ministries like finance, transport and take a multisectoral approach. In addition, collaborative work should be focused on one identified problem and expanded in a progressive manner. The experience with PSFHI showed that after the initial evaluation none of the countries except the Islamic Republic of Iran expanded the initiative.

The participants expressed the need to acknowledge and learn from the good work that has been achieved in Saudi Arabia and Jordan with the successful and sustainable establishment of national accreditation programmes.

5. THE CLINICAL GOVERNANCE APPROACH TO IMPROVE THE QUALITY OF CARE AND PATIENT SAFETY

5.1 Value of clinical governance in health care

The session started with a presentation of the concept of clinical governance as a framework by which organizations are accountable for continuously improving the quality of their services and safeguarding high standards of care by creating an environment in which excellence in clinical care will flourish. It provides a number of key strategic approaches, as well as operational interventions, which can accelerate improvement in each of the domains of clinical care quality.

The principles underlying clinical governance are accountability, leadership, teamwork, ownership and communication

Operational interventions that can accelerate improvement in quality are risk management, incident reporting, clinical standards, guidelines, audit, practitioner revalidation and patient and staff experience surveys. The level of application of these principles of clinical governance may be at any level macro (system-wide), meso (institutional) or micro (clinical service). Clinical governance adds value in various domains of the quality: safety and effectiveness and patients voice.

The National Health Service of the United Kingdom adopted the framework of clinical governance about a decade ago. By adopting the strategies and interventions for clinical governance a change towards achieving a coherent system at the level of the clinical service, health care institution and across the wider health care system could be made.

5.2   Experience with the patient safety approach to improve quality, safety and clinical governance in health care services

COHSASA has established various barriers to reduce the risk of the occurrence of adverse events. A facilitated reporting has been established in the health care system of South Africa. The reporting has been made more effective by using a call centre and a patient safety information system (PatSIS) to record incidents. The computer system captures, classifies and grades all incidents recorded. Once alerted, hospital staff can use PatSIS to access information provided to the call centre, manage incidents, monitor progress of the investigation, analyse recorded incidents and send reminders to responsible staff at monthly intervals until incident is closed, i.e. report completed and entered into the database. The events are categorized or coded according to their severity and action taken according to the level of the risk. The important benefits of using a PatSIS-like system are that it enables the identification of adverse events and near misses at all levels of participating health care establishments as they happen. Early recognition allows prevention programmes to be implemented to reduce the risk of recurrence and harm to patients and avoids litigation costs.

6.   QUALITY OF CARE AT THE PRIMARY CARE LEVEL

Primary care aims at providing comprehensive continuous and patient centred care. A quality primary health service must serve as a hub of coordination within a network that includes outside partners such as diagnostic services, specialized care, hospitals, nongovernmental organizations and prevention services.

The main areas of improvement in primary health care is the population at high risk (elderly), misdiagnosis, medication errors including incorrect treatment, prescription errors, failure to monitor patient's compliance and adherence with medication. There is a need for coordination across all levels of care like follow-up of the laboratory results, documentation communication especially for chronic care patients.

The participants discussed a draft proposal commissioned by WHO for the assessment and improvement of quality of care at primary health care level. The shared framework for quality of care assessment at primary health care covers seven main areas: a) coordination; b) accessibility and availability; c) comprehensiveness; d) equity; e) effectiveness; f) safety; and g) continuity of care.

The proposed indicators are distributed across a number of domains that will be finalized through a Delphi study: planning, management and organization, health workforce development, service provision, essential medicines and technology, community engagement and health information systems.

Feedback from the participants highlighted the importance of having quality indicators for the primary care level as a priority area in the Region. There is also a need for more clarification on the indicators and how to measure them along with a reference to be associated with each indicator. Participants expressed their willingness to be actively involved in the study.

7.   THE PREVENTION AND CONTROL OF HEALTH CARE-ASSOCIATED INFECTIONS TO ENHANCE PATIENT SAFETY

This session focused on WHO efforts to collect data on prevalence of multidrug-resistant organisms through surveys and the WHO multimodal strategy for reducing hospital-acquired infections and its implementation tools. Core components for infection prevention and control programmes have been outlined by WHO and more recently strategies to enhance patient safety were published. These strategies include checklists to prevent certain hospital-acquired infections by interventions that improve hand hygiene. The major components of the WHO Multimodal Improvement Strategy and its implementation tools are as follows.

System change: the right resources at the point of care. Implementation tools include surveys on the consumption of soap or hand rub and ward infrastructure, guides on the local production of alcohol hand rubs, protocols for evaluation and comparison of different alcohol based hand rubs for tolerability, acceptability and efficiency and system for self-assessment of compliance with hand hygiene.

Training and education. The implementation tools are the slides for the hand hygiene coordinator, trainers, observers and health care workers, hand hygiene training films and slides and key scientific publications, technical reference manual, frequently asked questions and information leaflet on glove use.

Evaluation and feedback. Some of the implementation tools are the hand hygiene self-assessment framework, observation form and compliance calculation form, hand hygiene knowledge questionnaire for health care workers and technical reference manual and perception survey for health care workers and senior managers.

Reminders in the workplace. Important implementation tools are the posters for the five moments for hand hygiene, how to hand rub and hand wash as well as leaflets, screen savers and videos on hand hygiene.

Institutional safety climate, and visible and meaningful leadership support. The implementation tools for a visible climate of safety include a template letter to advocate hand hygiene to managers, guidance on engaging patients and patient organizations in hand hygiene initiatives and promotional videos and DVDs.

8.   PATIENT SAFETY RESEARCH

Research in patient safety is essential to unveil the issues related to quality and safety of care and to identify solutions that improve it. At present there are gaps in the knowledge about the extent and burden of unsafe care.

The most important areas regarding safety and quality are hospital-acquired infections, surgery, medication and diagnosis. The various components of the knowledge base for patient safety are identifying risks and measuring harm, understanding causes, identifying solutions, evaluating impact and promoting change.

Core competencies to carry out patient safety research are: describing the fundamental concepts of patient safety; designing and conducting patient safety research and translating research evidence to improve the safe care of patients.

There is a substantial burden of unsafe care across the three country groups, although the nature of the problem may vary. Data are as yet insufficient to describe the epidemiology, impact and cost of unsafe care in the Region. There are large gaps in knowledge about priorities, solutions and strategies to reduce adverse events.

The current state of research in the Region and the requirements of a research programme were highlighted during this session as well as the main areas where research is needed to fill the gaps in knowledge.

WHO is facilitating research in patient safety by introductory course, guides for developing training programmes, introducing new methodologies for data poor set ups and offering grants.

A patient safety research programme for the Region should be adaptable to the health care context of the Region. It should also identify strategies for capacity building and develop local capacities for patient safety research, and build partnership and networking (South–South and North–South). Research methodologies adapted to the set-up may be used such as staff interview method, direct observation of medication safety process and nominal group technique, e.g. list of adverse drug events as perceived by the health care staff.

Challenges to patient safety research were also covered during this presentation, these are related to the low capacities related to patient safety research, the decisions are usually not supported by evidence and the research findings are not translated into policies. Priorities not well established and are not communicated to research centres. Funding for research remains an obstacle in many countries of the Region.

The discussion underscored the need for encouraging patient safety research as a core strategy to establish a comprehensive picture on patient safety problems and their scope as well as tailoring the interventions to tackle them. Participants also discussed the opportunities to improve knowledge and information sharing through the creation of a repository for

regional patient safety research papers as well as support establishing patient safety research networks among countries. The establishment of patient safety collaborating centres would encourage multi-site research and support the development of local capacities for patient safety research in the Region.

9.   NEXT STEPS

1.   Build on the previous efforts by the patient safety friendly hospital initiative.
     - Ministries of health to nominate 1–2 hospitals as pilots for PSFHI.
     - WHO to provide the tools and technical assistance for supporting implementation.
     - Disseminate the patient safety assessment manual and complete the patient safety toolkit.
2.   Conduct another mapping exercise on the status of health care accreditation in the Region.
     - WHO will update the regional status of accreditation based on standardized assessment instrument and develop a report.
     - Countries will provide the requested information on the status of accreditation.
3.   Promote clinical governance as a complementary approach to strengthening quality and safety initiatives in pilot hospitals.
     - Lead for clinical governance, organize appraisal meetings, set up a clinical governance committee, establish a feedback process, develop a communication strategy for all staff, set up groups or committees to look into causes of mortality, review clinical procedures and practice.
     - WHO and external experts will provide technical backup and support.
4.   Raise the issue of quality and safety at the policy level in countries.
     - Develop policy briefs on quality and safety and disseminate these widely.
     - Present the issue of quality and safety in policy forums such as the regional committee.
     - Bring quality and safety for discussion in national ministerial level forums.
5.   Undertake research in the area of quality and safety.
     - Identify priority areas for research in quality and safety for the three groups of countries of the Region.
     - WHO will provide the technical support in undertaking these activities.
     - Undertake joint efforts at mobilizing resources for research on patient safety.
6.   Intensify efforts to establish networks on quality and safety.
     - Establish a network of civil societies from the Region that are engaged in the work on quality and safety and build their capacity in raising the voice of patients and population at the country level.
     - Revive the network of quality and safety experts from the Region in order to provide technical support to countries in establishing quality and safety programmes.

Annex 1

PROGRAMME

Monday, 9 June 2014

08:30–09:00	Registration	
09:00–09:30	Inaugural session:	
	Holy Quran	*Dr Salem Al-Wahabi,*
	Welcome Speech of the Saudi Central Board for Accreditation of Health Institutions (CBAHI)	*Director General, CBAHI*
	Message from Dr Ala Alwan, WHO Regional Director for the Eastern Mediterranean	*Dr Sameen Siddiqi, Director Health System Development*
	Opening speech	*HE. Dr Adel Fakeih, Acting Minister of Health and Chairman of Health services Council, Saudi Arabia*
	Meeting objectives and expected outcomes Introduction of participants	*Dr Sameen Siddiqi, Director Health System Development*
09:30–09:50	Setting the scene: health care quality and patient safety in the Region	*Dr Sameen Siddiqi and Dr Mondher Letaief, WHO/EMRO*
09:50–10:30	Discussion	

Session 1: Quality improvement in health care Chair: Dr Salem Al-Wahabi

11:00–11:30	Updates on quality improvement approaches and accreditation of health care facilities	*Dr Charles Shaw, Health Care Quality, Hospital and Accreditation Expert, United Kingdom*
11:30–11:50	Health care quality and patient safety in GCC countries: current situation and perspectives.	*Dr Ahmed Al Mandhari, Sultan Qaboos University, Oman*
11:50–12:15	Health care quality and patient safety in GCC countries: current situation and perspectives	*Dr Abdelrahman K. Al-Habrawy Executive Board of the Health Ministers' Council for Cooperation Council States*
12:15–13:00	Discussion	

Session 2: Patient safety Chair: Dr Salma Jaouni

14:00–14:20	WHO patient safety programme	*Dr Itziar Laritzgoizia, WHO/HQ/SDS*
14:20–14:40	Updates on the regional patient safety interventions	*Dr Mondher Letaief WHO/EMRO*
14:40–15:20	Country experiences on patient safety programmes: Saudi Arabia: *Dr Yacoub Neyaz* Oman: *Dr Ahmed Al-Mandhari* Jordan: *Dr Safa El Qsoos* Egypt: *Dr Nagwa Husseini*	
15:20–16:30	Discussion	
17:00–17:30	Panel discussion on challenges to address patient safety in the Eastern Mediterranean Region	*Dr Sameen Siddiqi, Dr Yacoub Neyaz, Prof. Mahi Al- Tehewy, Dr Safa Qsoos*

Tuesday, 10 June 2014

Session 3: Accreditation in health care Chair: Dr Nagwa Husseini

08:30–08:50	Review of evidence and value of Accreditation in health care	*Dr Charles Shaw, United Kingdom*
08:50–09:10	ISQua's international accreditation programme/support to low–middle income countries	*Mr John Sweeney, CEO of Health Care Informed (HCI), member of the ISQua Board, Ireland*
09:10–09:30	Regional mapping of accreditation programmes in the Region	*Prof. Mahi Al-Tehewy, Egypt*
09:30–10:30	Discussion	
11:00–11:20	Overview on the health care accreditation programme in Saudi Arabia	*Dr Abdulelleh Al-Hawsawi, CBAHI*
11:20–11:40	Health care accreditation programme of Jordan	*Dr Salma Jaouni, CEO, Health Care Accreditation Council, Jordan*
11:40–12:00	Overview of the accreditation programme from the Council for Health Service Accreditation of Southern Africa (COHSASA)	*Dr Stuart Whittaker. CEO, The Council for Health Service Accreditation of Southern Africa (COHSASA)*
12:00–13:00	Discussion	

14:00– 14:20	The value of clinical governance to improve quality and safety in health care	*Dr Sean O'Kelly, Executive Medical Director, University Hospitals Bristol NHS Foundation Trust, NHS, United Kingdom*
14:20–14:40	Experience with the patient safety approach to improve quality, safety and clinical governance in health care services	*Dr Stuart Whittaker, COHSASA*
15:00–15:10	Overview on quality and safety improvement initiatives in primary care	*Dr Itziar Laritzgoizia, WHO/HQ/SDS*
15:10–15:30	Quality improvement in primary care: a proposal for development and validation of specific indicators and standards	*Dr Mondher Letaief, WHO/EMRO*
15:30–16:15	Discussion	
16:45–17:30	Group work to come out with future actions needed for rolling out quality and safety in moving towards universal health coverage: Group 1: Bahrain, Saudi Arabia, Kuwait, Oman Group 2: Egypt, Jordan, Lebanon, Morocco, Tunisia Group 3: Djibouti, Pakistan, Somalia, Sudan, Yemen	

Wednesday, 11 June 2014

Session 4: Patient safety research Chair: Dr Sameen Siddiqi

08:30–09:30	Group presentations and discussions	
09:30–10:00	Programmes for the prevention and control of health care-associated infections to enhance patient safety – from what to how	*Mrs Claire Kilpatrick, WHO Consultant, United Kingdom*
10:00–10:30	Discussion	
11:00–11:20	Patient safety research approaches and priorities	*Dr Itziar Laritzgoitia (WHO/HQ/SDS)*
11:20–11:40	Patient safety research	*Dr Mondher Letaief (WHO/EMRO)*
11:40–12:30	Panel discussion on patient safety research	*Dr Itziar Laritzgoitia, Dr Stuart Whittaker, Dr Al Hawsawi and Dr Mondher Letaief*
12:30–13:00	Recommendations	
13:00–13:30	Closing ceremony	

Annex 2

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