NATIONAL POLICY ON

HEALTHCARE QUALITY AND SAFETY

Ministry of Health
"Suwasiripaya"
385, Rev.Baddegama Wimalawansa Thero Mawatha,
Colombo 10,
Sri Lanka
2021

NATIONAL POLICY ON

HEALTHCARE QUALITY AND SAFETY

Content

	Page
Introduction	1
Vision, Mission and Goal	8
Key Result Areas	9
KEY RESULT AREA 1: CUSTOMER / PATIENT SATISFACTION AND EXPERIENCE	10
KEY RESULT AREA 2: LEADERSHIP, GOVERNANCE AND SYSTEMS	12
KEY RESULT AREA 3: CLINICAL EFFECTIVENESS	14
KEY RESULT AREA 4: RISK MANAGEMENT AND SAFETY	16
KEY RESULT AREA 5: ENABLING A CULTURE FOR QUALITY IMPROVEMENT	18
KEY RESULT AREA 6: STAFF DEVELOPMENT AND WELLBEING	20
KEY RESULT AREA 7: RESEARCH FOR QUALITY IMPROVEMENT AND PATIENT SAFETY	22
References	24

Introduction

Sri Lanka provides free healthcare services to all the citizens irrespective of their status, income or geographic location and has achieved remarkable health outcomes, particularly relative to neighboring countries with a similar income range. Ensuring accessibility for free, quality healthcare on equitable basis is the main focus of the healthcare service of Sri Lanka since its inception. Despite being a low-middle income country, Sri Lanka exhibits excellent health indices including life expectancy at birth, maternal mortality and infant and child mortality rates.

Even though the hospitals provide good services to the public, the services are not well recognized by the public. However, many hospitals have taken their own initiatives to improve the services by means of improving infrastructure, introducing monthly performance reviews, preparing manuals and guidelines, initiating productivity improvement programmes.

The Sri Lankan healthcare system is also experiencing major changes, notably in the provision and maintenance of quality and safety in healthcare systems, within its limited resources.

The National Policy on Healthcare Quality and Safety for Sri Lanka[1] formulated in 2015 aimed at achieving a higher quality of life for its citizens by identifying the roles and responsibilities of the Government and Private Institutions, in relation to better provision of curative and preventive care and implementing the strategies through specific programs island wide.

In August 2019, the Directorate of Healthcare Quality & Safety (DHQS) requested the WHO to support reviewing the policy on healthcare quality and safety and the development of a Strategic Plan for Patient Safety and Quality of Care for 2021-2024 to systematically implement the national policy. DHQS obtained external technical assistance through the WHO, stakeholder working groups were identified and the strategic plan was developed for the Key Results Areas of the national policy with stakeholder consensus.

The national policy was revised to emphasize the importance of local leadership, ownership, data management and peer benchmarking. The successful implementation of the policy will bring patient safety and healthcare quality in Sri Lanka to the next level, achieving mature status for the patient safety and quality processes, in consistent with the global patient safety standards and supporting the 2019 World Health Assembly resolution on Global Action on Patient Safety and seven dimensions of healthcare quality.

Global Situation

On 28 May 2019, the 72nd World Health Assembly (WHA) adopted the WHA Resolution (WHA72.6) 2, 3 on 'Global action on patient safety', including the establishment of an annual World Patient Safety Day on 17 September. Universal Health Coverage (UHC) entails that all individuals and communities receive the health services they need without suffering financial hardship. It includes the full spectrum of essential, quality health services, from health promotion to prevention, treatment, rehabilitation, and palliative care. At present, Patient Safety is recognized as a global health priority and identified as essential and fundamental component for the achievement of Universal Health Coverage in all countries.

The resolution urges countries on the following actions to improve patient safety and quality of healthcare:

(1) To recognize patient safety as a health priority in health sector policies and programmes, making it an essential component for strengthening health care systems in order to achieve universal health coverage;

(2) To assess and measure the nature and magnitude of the problem of patient safety including risks, errors, adverse events and patient harm at all levels of health service delivery including through reporting, learning and feedback systems that incorporate the perspectives of patients and their families and to take preventive actions and implement systematic measures to reduce risks to all individuals;

(3) To develop and implement national policies, legislation, strategies, guidance and tools and deploy adequate resources, in order to strengthen the safety of all health services as appropriate;

(4) To work in collaboration with other countries, civil society organizations, patients' organizations, professional bodies, academic and research institutions, industry and other relevant stakeholders to promote, prioritize and embed patient safety in all health policies and strategies;

(5) To share and disseminate best practices and encourage mutual learning to reduce patient harm through regional and international collaboration;

(6) To integrate and implement patient safety strategies in all clinical programmes and risk areas as appropriate to prevent avoidable harm to patients related to health care procedures, products and devices, for example, medication safety, surgical safety, infection control, sepsis management, diagnostic safety, environmental hygiene and infrastructure, injection safety, blood safety and radiation safety, as well as to minimize the risk of inaccurate or late diagnosis and treatment, and to pay special attention to at-risk groups;

(7) To promote a safety culture by providing basic training to all health professionals, developing a blame-free patient safety incident reporting culture through open and transparent systems that identify and learn from examining causative and contributing factors of harm, addressing human factors, and building leadership and management capacity and efficient multidisciplinary teams, in order to increase awareness and ownership, improve outcomes for patients and reduce the costs related to adverse events at all levels of health systems;

(8) To build sustainable human resource capacity, through multisectoral and interprofessional competency-based education and training, based on the WHO patient safety curricula and continuous professional development, to promote a multidisciplinary approach, and to build an appropriate working environment that optimizes the delivery of safe health services;

(9) To promote research, including translational research, to support the provision of safer health services and long-term care;

(10) To promote the use of new technologies, including digital technologies, for health, including to build and scale up health information systems and to support data collection for surveillance and reporting of risks, adverse events and other indicators of harm at different levels of health services and health-related social care, while ensuring the protection of personal data, and to support the use of digital solutions to provide safer health care;

(11) To consider the use of traditional and complementary medicine, as appropriate, in the provision of safer health care;

(12) To put in place systems for the engagement and empowerment of patients' families and communities (especially those who have been affected by adverse events) in the delivery of safer health care, including capacity-building initiatives, networks and associations, and to work with them and civil society, to use their experience of safe and unsafe care positively in order to build safety and harm-minimization strategies, as well as compensation mechanisms and schemes, into all aspects of the provision of health care, as appropriate.

The regional strategy for patient safety in the WHO South-East Asia Region (2016-2025)[6] was developed by WHO expert working group in 2015, to support the development of national patient safety strategies within the Region including Sri Lanka. The guiding principles are:

a. Focusing on health systems improvement;
b. Strengthening capacity through education and training;
c. Learning from mistakes and minimizing risks in future;
d. Adopting a patient-centred approach;
e. Targeting all levels of healthcare;
f. Introducing evidence-based interventions;
g. Establishing priorities;
h. Identifying implementing agencies and ensuring sustainability.

The objectives of the patient safety strategy as per the regional strategy for patient safety in the WHO South-East Asia Region (2016-2025) are to:

1. Improve the structural systems to support quality and efficiency of healthcare and place patient safety at the core of all levels of healthcare;
2. Assess the nature and scale of harm to patients and establish a system of reporting and learning at the national level;
3. Ensure a competent and capable workforce that is aware and sensitive to patient safety;
4. Prevent and control health care-associated infections;
5. Improve implementation of global patient safety campaigns and strengthen patient safety in all health programmes; and
6. Strengthen capacity for and promote patient safety research.

National Policies that Influence Healthcare Quality and Safety Policy

The Government's policy has identified the importance of quality in healthcare and stated that excellence in healthcare is to be achieved through the provision of patient focused, comprehensive and high-quality service. The government working in partnership with the private sector, will ensure equitable access to the health services. The National Health Policy of Sri Lanka has pointed out that Healthcare will be made more accessible to the community on an equitable basis with provision for meeting specific health needs, improving the quality of healthcare to a level acceptable to both the community and service providers; and healthcare will be made more efficient and cost effective.

The main goal of the Government Health Policy is to provide high quality patient care by reorganizing the healthcare delivery system, especially at district and provincial levels. This is in line with the National Quality Policy of Sri Lanka which envisages an integrated approach to quality management involving all sectors of the economy and all segments of society.

Enhancement of Quality of Service Delivery is one of the major components in the Health Master Plan. A quality assurance strategy has to be developed to facilitate the delivery of high-quality services central to the ethos of the heath sector. The Ministry of Health will lead in developing quality assurance in a systematic manner that enhances team spirit and patient- and consumer-focus and builds on the existing quality improvement programs. This approach will include clinical accountability, development of peer group review and clinical audits, as well as methods of monitoring patient satisfaction and total quality management of services.

A system of continuous professional education for doctors, nurses and other healthcare workers, at regular intervals, is required, with the appropriate professional and regulatory bodies involved as stakeholders. Clear protocols and accreditation processes need to be introduced to upgrade and sustain standards in both the state and private sector. In order to ensure sustainability, professional organizations, medical faculties and service providers will be involved in the developmental process.

History of Healthcare Quality & Safety in Sri Lanka

The evolution of a National Quality Assurance Programme in Sri Lankan Health Services dates back to 1989. With the publishing of the handbook on the National Quality Assurance Programme in 1995 by the Ministry of Health, some institutions embraced the concept to introduce quality improvement programmes in their own institutions. The Quality Assurance Programme was re-launched in 2000 with the concept 'Quality Healthcare through Productivity'.

The Castle Street Hospital for Women (Teaching) and then the Castle Street Hospital was identified as the focal point for the National Quality Assurance Programme of the Ministry of Health. Since then measures have been taken to expand this programme to other hospitals island wide. As a result, hospitals such as Ampara DGH, Peradeniya TH and Kurunegala PGH have initiated their quality improvement programmes. It was believed that quality improvement programmes can be implemented only in the line ministry institutions because of the limited availability of resources in other hospitals. The Quality improvement programme at Mahiyangana BH in 2004 - 2005 paved the path for hospitals which are governed by Provincial Councils and other smaller hospitals to improve quality in their hospitals.

With this experience, a pilot study was carried out in five hospitals of different administrative levels in North Western Province. This gave an insight on carrying out of the quality improvement programme for the Ministry of Health. Along with this experience, in 2007-2009, the programme was expanded to eight hospitals in the Southern and Uva Provinces. With these pilot studies, it was identified that the establishment of a District Quality Assurance Unit and Quality Management Units are important to facilitate and monitor the quality improvement programme. It was also recommended to establish an apex body, in order to facilitate the quality improvement programme throughout the country. To initiate the process, a building was constructed for the National Quality Assurance Programme, with the aid of World Bank – HSDP funds...

A consultative committee was appointed to decide on the scope and functions of the Directorate of Healthcare Quality and Safety which was commissioned in August 2012. The Directorate functions under the principle of 'A Centrally Driven, Locally Lead, Clinically Oriented, Patient Centered, Continuous Quality Improvement Programme'. Since its inception, the Directorate has carried out much good work related to the quality improvement program me of the Ministry of Health in a planned manner. These include the commencement of Monitoring and Evaluation mechanisms and Quarterly Performance Review meetings for 42 Healthcare Institutions affiliated to Line Ministry –; and biannual reviews for 101 healthcare institutions in Provincial level, which include all hospitals from Base Hospitals Type B and above. In The Directorate created a platform for healthcare institutions to share their experiences related to healthcare quality and safety in 2013.

In 2013, twenty General Indicators and Performance Indicators were introduced to evaluate healthcare institutions. Surgical Safety Checklist was also introduced in the same year to ensure patient safety in surgeries, with circular instructions and guidelines. In 2015, the National Policy on Healthcare Quality and Safety was developed and published. On the same year, the Directorate could publish the Master Trainers Manual on Quality and Safety in all three languages. Annual trainings were initiated with Training of Trainers workshops on quality concepts including, 5S, Continuous Quality Improvement (CQI) and Total Quality Management (TQM) and Training Workshops on Patient Safety, for middle and top-level managers of hospitals. In 2016, Adverse Event Reporting Mechanism was established and Readmission Forms and Guidelines were introduced. Training on Clinical Audits was introduced in 2017. A Tele Documentary on 'Responsiveness in Healthcare' was produced and launched. Directorate of Healthcare Quality & Safety took the initiative of introducing the clinical Indicators for four major specialties in 2017.

With the declaration of World Patient Safety Day by WHO on 17th September 2019, DHQS initiated celebrating the event in Sri Lanka at national and regional levels.

In 2020 website for DHQS was developed and launched in parallel to the celebrations of World Patient safety day. On this day, the iconic lotus tower was illuminated in orange in recognition of all healthcare workers' commitment during the COVID 19 pandemic.

Vision, Mission, and Goal

Vision

Providing optimum quality and safe healthcare services to the people of Sri Lanka

Mission

Facilitating healthcare institutions to provide best possible quality healthcare services through continuous improvement while responding to peoples' expectations and ensuring safety with involvement of all stakeholders

Goal

To sustain continuous quality improvement of healthcare services that ensure clinical effectiveness and patient safety while addressing the non-health expectations of the people

The following seven Key Result Areas constitute the Healthcare Quality and Safety Policy of the government. The Policy Statement is structured on the basis of a rationale for each Objective which are accompanied by set of illustrative strategies. The strategies for achieving the Objectives will be implemented through specific interventions which have been developed by the stakeholder working groups, mandated to formulate the Strategies and Action Plan for Healthcare Quality and Safety. In the Strategies and Action Plans, the roles and responsibilities of the national and provincial Administrators, NGOs and the Private Sector are identified. The development of mechanisms for co-ordination and the provision of adequate resources are necessary in order to responsive, quality and safe healthcare service is enabled for the general population.

NATIONAL POLICY ON HEALTH CARE QUALITY AND SAFETY

Key Result Areas

1. Customer/ Patient Satisfaction and Experience - To strengthen organizational settings towards customer-focused care responsive to their preferences, expectations and values and patient-centred care

2. Leadership, Governance and Systems - To establish effective leadership and develop governance and systems to facilitate healthcare quality improvement and patient safety.

3. Clinical Effectiveness - To promote evidence-based, ethically accepted clinical practices to ensure the best possible outcome for the patient.

4. Risk Management and Safety - To mitigate risk from medications, procedures and adverse events to ensure safety of patients and staff.

5. Enabling a Culture for Quality Improvement - To internalize quality improvement strategies to assure shared values in creating health promoting and environment friendly healthcare organizations.

6. Staff Development and Wellbeing - To develop a competent, healthy and satisfied workforce to enhance productivity, quality and safety in healthcare.

7. Research for Quality Improvement and Patient Safety - To promote research in the field of quality improvement and patient 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.

Rationale

In line with global action for patient safety and national policy for the provision of patient focused, comprehensive and high-quality service, it is important to put in place systems for the engagement and empowerment of patients' families and communities. Understanding customer values and preferences, grounded in strong communication and trust, is key.

Listening to patients' narratives and stories about their experiences can often provide insight into their expectations of care in a more engaging manner than quantitative data. Patients value good health-care experience. International studies consistently indicate on certain areas and aspects that patient's value most. Being related with dignity and respect; having confidence and trust in providers; courtesy and availability of staff; continuity and smooth transitions; coordination of care; pain management and physical comfort; respect for preferences; and emotional support are some of these aspects.

Health services should develop measures of patient centeredness, satisfaction and experience. All patients should be made aware of and take advantage of every opportunity to provide feedback (e.g., participate in surveys and focus groups) to improve the design and evaluation of healthcare systems that reflect patients' diverse needs and preferences.

The challenge to health systems is to ensure that engagement with patients and the population is at the heart of all policies and strategies for quality improvement, and that this commitment is translated into meaningful action.

Patients are to be placed firmly at the heart of the health system, highlighting that patients should be considered as partners of their care and their recovery, reflecting a patient-centric care. Involving patients in their care can increase their satisfaction, enhance their experiences, improve health outcomes and reduce the likelihood of healthcare harm.

STRATEGIES:

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

KEY RESULT AREA 2: LEADERSHIP, GOVERNANCE AND SYSTEMS

OBJECTIVE:

To establish effective leadership and develop governance and systems to facilitate healthcare quality improvement and patient safety.

Rationale

A strong leadership commitment is fundamental to patient safety and quality. The institution/ organization/healthcare facility must recognize patient safety and quality as a priority. In order to facilitate quality improvement and patient safety effectively, the institution leadership needs to establish a policy framework for patient safety and quality with stakeholders, aligned with the national policy and prepare a patient safety and quality implementation and action plan based on strategic priorities. Action plans should be monitored by hospital leadership on periodic basis for effectiveness.

The delivery of high quality, patient-centered care requires the concerted efforts of many healthcare professionals. There is also growing evidence that effective multidisciplinary team working well together improves patient outcomes. Ward rounds are one common example of multidisciplinary team working in a clinical setting.

In order to ensure continuous quality improvement, it is important to develop effective mechanisms for performance assessment & peer benchmarking and sharing of best practices of quality and safety concepts & models. Accreditation is an important mechanism to ensure the good standards of healthcare quality and safety. Assessments are usually undertaken by an independent body with trust earned from commitment, integrity and neutrality. Inspection and accreditation at varying levels can be provided as appropriate to the resources available in the country. It is important to link and encourage peer performance benchmarking and accreditation to local & national recognition & appreciation. These can include awards, incentives and recognition of quality status attainment at various levels and forums. A spirit of both healthy peer competition and strong peer collaboration at the regional, provincial and national level should be inculcated to propel quality improvement and interest.

Regulation and standards are important in the quest for quality improvement in health systems. Setting standards and monitoring adherence to them are efficient means of facilitating better compliance with evidence. Quality monitoring needs to be based on a well-functioning national information infrastructure. The internet is increasingly used as an effective tool for the public release of information on quality of care.

The key for performance assessment, systematic review and corrective action in healthcare is to strengthen the information system to support the quality improvement and patient safety programmes. Decision on quality improvement is based on data and should be knowledge driven for effective use. Focus on standardization of data and the creation of essential standard data sets are important for collection, analysis and benchmarking.

STRATEGIES

1. Recognize healthcare quality and safety as a priority by the leadership
2. Facilitate development and implementation of institutional action plans based on National policy on Healthcare Quality and Safety
3. Establish standards in healthcare quality and safety towards accreditation
4. Ensure continuous quality improvement in accordance with National Policy on Healthcare Quality and Safety
5. Ensure Total Quality Management (TQM) through engagement and shared responsibility of all stakeholders in the internal and external environment
6. Strengthen the Information System to support the quality improvement programmes
7. Develop/ adopt and/or strengthen mechanisms for performance assessment using data driven quality monitoring system for corrective action in healthcare
8. Strengthen quality of primary health care, services and conduct regular supervision
9. Develop a mechanism for inter-sectoral collaboration and advocacy for healthcare quality and safety

KEY RESULT AREA 3: CLINICAL EFFECTIVENESS

OBJECTIVE:

To promote evidence-based, ethically accepted clinical practices to ensure the best possible outcome for the patient.

Rationale

Evidence-Based Practice (EBP) is the judicious use of current best evidence in conjunction with clinical expertise and patient values to guide health care decisions. EBP has been shown to be a powerful tool that can be used for various purposes and by different stakeholders in health care systems. Evidence based clinical protocols and guidelines can be developed in order to minimize variation and improve clinical outcomes.

Clinical Audit is a process that has been defined as a quality improvement process that seeks to improve patient care and outcomes through systematic review of care against explicit criteria derived from consensus or EBP, and the implementation of change. Clinical Audit forms the system for improving standards of clinical practice. Aspects of patient care are evaluated against expected standards of care and where necessary, changes are made at an individual, team or service level. A re-audit can then be used to confirm that improvements have been effective.

Clinical Peer Review is the process by which health care professionals, evaluate other departments'/institutions' clinical performance. The main purpose of peer review is to improve the quality and safety of care. It also serves to meet regulatory requirements and to assure that professionals are competent and practice within the boundaries of professionally accepted norms. Peer benchmarking, peer networking & peer learning, and sharing are also powerful mechanisms to improve care and spread best practices.

In today's healthcare setting, there is a need to assess and promote the use of new technologies, including digital technologies, for patient quality and safety. These include the need to build and scale up health information systems and to support data collection for surveillance and reporting of risks, adverse events and other indicators of harm at different levels of health services and health-related social care, while ensuring protection of personal data.

The central ethical aspects of modern medical practice are clinical competence, respect for patients and their health care decisions, and maintaining the primacy of patient's need in the face of external pressure in a changing social, economic, and political climate. Ethical issues include those relating to patient confidentiality, patient relationships, malpractice and negligence and informed consent. For high quality care, there is a need to address issues and establish mechanisms to ensure ethical practices within the clinical care.

STRATEGIES

1. Develop and institutionalize evidence-based cost-effective clinical guidelines and protocols
2. Provide professional guidance to promote clinical audits
3. Develop mechanisms for peer review, peer benchmarking, peer networking and peer review learning & sharing of clinical practices
4. Strengthen the clinical information management system to facilitate decision making
5. Establish mechanisms to ensure ethical clinical practice

KEY RESUT AREA 4: RISK MANAGEMENT AND SAFETY

OBJECTIVE:

To mitigate risk from medications, procedures and untoward events to ensure safety of patients and staff.

Rationale:

Clinical risk management is concerned with improving the quality and safety of healthcare services by identifying the circumstances and opportunities that put patients at risk of harm and then acting to prevent or control those risks. A clinical adverse incident is any unplanned event which causes, or has the potential to cause (near miss), harm to a patient. It is recommended for these incidents to be reported so that risks to patient safety are recognized and actions are taken to prevent recurrence.

Severe adverse event (sentinel event) is an unanticipated event in a healthcare setting resulting in death or serious physical or psychological injury to a patient or patients, not related to the natural course of the patient's illness. In view of the seriousness on the event, the healthcare institution is expected to prepare a root- cause analysis and action plan to rectify the issues identified within a certain time frame.

For patient safety and high-quality care, it is important to integrate and implement patient safety strategies in all clinical programmes and risk areas, as appropriate, to prevent avoidable harm to patients. The risk areas include those related to health care procedures, products and devices, for example, medication safety, surgical safety, infection control, sepsis management, diagnostic safety, environmental hygiene and infrastructure, injection safety, blood safety and radiation safety, as well as to minimize the risk of inaccurate or late diagnosis and treatment, and to pay special attention to at-risk groups.

Prompt identification of events is important. The establishment of an effective risk management system and a reporting system will ensure patient safety while providing the highest quality care. The aim is to build up a committed hospital system which provides a responsive and safe healing environment for patients and their families. It is thus vital to promote a safety culture by providing basic training to all health professionals, developing a blame-free patient safety incident reporting culture through open and transparent systems that identify and learn from examining causative and contributing factors of harm, addressing human factors, and building leadership and management capacity and efficient multidisciplinary teams, in order to increase awareness and ownership, improve outcomes for patients and reduce the costs related to adverse events at all levels of health systems.

STRATEGIES:

1. Ensure an effective risk management system with active surveillance and periodic risk evaluations
2. Strengthen an effective reporting system for adverse events and near-misses
3. Establish a mechanism for focused investigations of severe adverse events (sentinel events)
4. Expand mortality reviews
5. Strengthen mechanisms for safe practice
6. Strengthen infection prevention and control
7. Mitigate unintended harm from medication and medical devices
8. Establish effective communication for patient and staff safety
9. Ensure safe environment

KEY RESULT AREA 5: ENABLING A CULTURE FOR QUALITY IMPROVEMENT

OBJECTIVE:

To internalize quality improvement strategies to assure shared values in creating health promoting and environment friendly healthcare organizations.

Rationale:

Quality improvement (QI) is a systematic, formal approach to the analysis and the improvement of healthcare performance. QI focuses on planning, collecting and analyzing data and testing of changes.

The culture of an organization is the embodiment of the core values, guiding principles, behaviors, and attitudes that collectively contribute to its daily operations. Culture drives the policies, practices, and processes used to accomplish an organization's work. The lack of quality-oriented culture within a health institution contributes exceedingly towards the occurrence of unwanted and unaccepted errors in the system. Enabling culture for quality improvement in healthcare improves healthcare quality. Healthcare organizations with quality culture meet the needs of all patients, including poor people and other disadvantaged groups. The establishment of such a culture at a health institution is a collective effort of the hospital staff, patients and the community.

Since quality improvement is a structured organizational process, the establishment and/or strengthening of Quality Improvement Teams (QIT) and Work Improvement Teams (WITS) within an institution promotes teamwork among healthcare workers. This will assure continuous flow of improvement to provide quality and safety in healthcare that meets the expectations of the public. Promoting a proactive culture aimed at quality and safety while reinforcing interventions and energizing the staff to continue with provision of patient safety, will consequently assure a healthcare facility to be a safe place for patients.

Spiritual health has been defined as a state of being where an individual is able to deal with day- to- day life issues in a manner that leads to the realization of one's full potential, meaning and purpose of life and fulfilment from within. Spirituality means different things to different people. It may include faith or what provides a sense of personal meaning in life (and death). When dealing with illness, spiritual issues often come to the forefront of the patient's life, as well as to the staff. Cure is not possible for many illnesses, but that there is always room for healing. Healing can be experienced as acceptance of illness and peace

with one's life, and is at its core spiritual. Compassionate care calls healthcare staff to walk with people in the midst of their pain, to be partners with patients rather than experts dictating information to them. Improving spiritual health in an organization enhances its overall healthcare mission.

Health promotion is the process of enabling people to increase control over their health and its determinants, and thereby improve their health. Increasing participation and awareness of staff, patients and community of health promotion knowledge and activities is key in sustaining a health promoting culture in health facilities.

STRATEGIES

1. Strengthen quality culture in healthcare organizations
2. Promote a proactive safe culture in healthcare institutes
3. Ensure quality culture by benchmarking and sharing best practices with peer and external healthcare organizations
4. Develop a mechanism to encourage team work and spiritual health in healthcare institutions

KEY RESULT AREA 6: STAFF DEVELOPMENT AND WELLBEING

OBJECTIVE:

To develop a competent, healthy and satisfied workforce to enhance productivity, quality and safety in healthcare.

Rationale:

Modern healthcare is extremely complex and is delivered in a dynamically changing environment. This present challenges at every level within the system to ensure that there is a modern, competent health workforce which is fit for purpose and provides the patient with appropriate care, delivered by the right person in the right environment.

Human resource is the most valuable asset of an institution. Within many health care systems worldwide, increased attention is being focused on Human Resources Management (HRM). Specifically, human resources are one of three principle health system inputs, with the other two major inputs being physical capital and consumables. Healthcare professionals face many obstacles in their attempt to deliver high-quality health care to citizens. Some of the major obstacles are lack of continuous training programme, professional support, team work in the healthcare institutions etc.

Policies, practices and procedures related to improving quality & safety in healthcare should also aim at developing professional skills, knowledge and attitudes of the staff, to improve the effectiveness and efficiency of their performance, in achieving productivity, quality and safety in healthcare. It is critical to build sustainable human resource capacity, through multi-sectoral and inter-professional competency-based education and training, based on the WHO patient safety curricula[7] and continuous professional development. This will promote a multidisciplinary approach, and build an appropriate working environment that optimizes the delivery of safe health services.

Making employees happy and satisfied will maintain their morale and motivation high so that, they will contribute effectively and efficiently towards the overall improvement of a healthcare facility. Every process change involving quality and patient safety requires training. Effective engagement by leadership and HR at every level of the organization is the key for the success of staff wellbeing initiative. A safe working environment for staff is essential.

STRATEGIES

1. Establish mechanisms to strengthen professionals attitudes and competencies of healthcare staff for ensuring healthcare quality and safety
2. Facilitate continuous professional education and development of staff
3. Strengthen mechanisms to staff appraisal, reward creativity and innovation among staff for quality improvement and patient safety
4. Design and implement activities to support staff wellbeing and enhance job satisfaction

KEY RESULT AREA 7: RESEARCH FOR QUALITY IMPROVEMENT AND PATIENT SAFETY

OBJECTIVE:

To promote research in the field of quality improvement and patient safety.

Rationale:

Research in the field of quality improvement and patient safety are important to help healthcare institution improve their quality healthcare service and to support the provision of safer health services.

Research areas can include but are not limited to: Performance Measurement Research; Patient Safety Culture Research; System & Structure for Safe Patient Care; Spreading and Implementation of Impactful Practices; Healthcare Simulation for Safe Patient Care; Diagnostic Error and Performance; Ambulatory Patient Safety Research. Research helps an institution to identify areas which need more improvements. It also helps to assess whether changes made have resulted in visible improvements of the system and allows a pathway to obtain, analyze and interpret performance data while comparing those with baseline data. By sharing the knowledge gained from these research, an institution can inspire the spirit of motivation that fuels the passion for improving health and delivery of healthcare.

Another problem that often plagues progress in global health is the slow translation of research into practice. Often, a disconnect exists between those who create the evidence base and those who are positioned to implement the research findings. It is important to enhance dissemination and use of research findings and best practices. Proactive measures can be taken to encourage the uptake of evidence-based practices.

Conducting research in the area of patient safety and improvement of care delivery requires various research and analytical skills. These include but are not limited to: analytical skills for performance measurement and benchmarking, programme evaluation, implementation evaluation, technology assessment and cost effectiveness studies. In addition, epidemiological and informatics skills of healthcare staff should be nurtured for patient safety and quality programmes.

STRATEGIES

1. Promote research in healthcare quality and safety for evidence-based management in healthcare safety
2. Promote development of research expertise pool for enhancing skills of healthcare staff for conducting research
3. Enhance dissemination and use of research findings

References

1. Ministry of Health, Nutrition and Indigenous Medicine, Sri Lanka. National Policy on Healthcare Quality and Safety 2015. Directorate of Healthcare Quality & Safety (DHQS) Ministry of Health, Nutrition and Indigenous Medicine, Sri Lanka 2015.

2. World Health Organization. Global action on patient safety: WHO Director General report to 72nd World Health Assembly, 2019. Geneva: World Health Organization, 2019.

3. World Health Organization. Resolution WHA 72.6: Global action on patient safety. Geneva: World Health Organization, 2019. http://apps.who.int/gb/ebwha/pdf_files/WHA72/A72_R6-en.pdf

4. World Health Organization. Handbook for national quality policy and strategy: a practical approach for developing policy and strategy to improve quality of care. World Health Organization, 2018. https://apps.who.int/iris/handle/10665/272357 .

5. World Health Organization. Patient Safety Essential Functions for achieving Universal Health Coverage. Framework for Patient Safety Assessment and Improvement Version - 2.0 (under Field Testing) WHO. 7th August 2018

6. World Health Organization. Regional strategy for patient safety in the WHO South-East Asia Region (2016-2025). World Health Organization, Regional Office for South-East Asia (SEARO) 2015. https://apps.who.int/iris/bitstream/handle/10665/205839/B5215.pdf?sequence=1&isAllowed=y

7. World Health Organization. WHO patient safety curriculum guide: multi-professional edition. World Health Organization 2011.
https://www.who.int/patientsafety/education/mp_curriculum_guide/en/