



Defining patient safety

 The reduction of risk of unnecessary harm associated with health care to an acceptable minimum. (WHO, World Alliance for Patient Safety 2009).







Definition of patient safety culture

An integrated pattern of individual and organizational behavior, based on a system of shared beliefs and values, that continuously seeks to minimize patient harm that may result from the process of care delivery.







AHF Mission

- Raise Quality, Safety, efficiency and Good Governance in the Arab Healthcare Sector
- Encourage initiatives, Good Governance, Effective Leadership and implement Value Based Care Delivery Practices and Strategies
- Influence health policies with Decision Makers, Healthcare Organizations and assure High Quality Services for the Arab Patients









AHF Strategic plan for 2022-2025

- ARAB DIGITAL HEALTH STRATEGY
- THE DISASTER & EMERGENCY PREPAREDNESS PLAN
- NEW VISION FOR THE HEALTHCARE FACILITIES DESIGN
- THE ARAB CENTER FOR HEALTHCARE SUSTAINABILITY

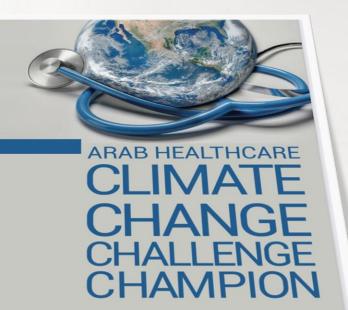






EXTERIOR BUILDING ELEMENTS INTERIOR BUILDING ELEMENTS FIRE SAFETY/ CODE COMPLIANCE **GROSS FLOOR AREA CALCULATIONS ENERGY CONSERVATION** WATER CONSERVATION













MUSCAT DECLARATION FOR PATIENT SAFETY 2018

"FIRST DO NO HARM"



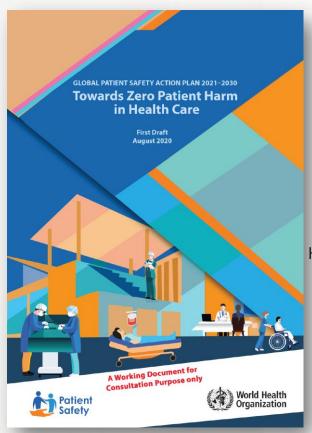


April 2018









Vision

A world in which no patient is harmed in health care, and everyone receives safe and respectful care, every time, everywhere

Governments Health care facilities



Stakeholders World Health Organization

Mission

Drive forward policies and actions to minimize, and where possible, eliminate all sources of risk and patient harm in health care based on science, strategic partnerships and patient-centredness

Goal

Achieve the maximum possible reduction in avoidable harm due to unsafe health care globally



Information Patient and family High reliability and research engagement systems Policies¹ Safety Health Synergies, for worker of partnerships zero patient clinical education and skills harm processes and solidarity



- Patient safety is a framework of organized activities that creates cultures, processes, procedures, behaviours, technologies, and environments in health care that consistently and sustainably: lower risks, reduce the occurrence of avoidable harm, make error less likely and reduce its impact when it does occur.
- In 2020, the toll from COVID-19 global pandemic has brought increased recognition of risks to patients.





The framework includes seven strategic objectives, which can be achieved through 35 specific strategies.

Build high reliability health systems and health organizations that protect patients daily from harm.

2

Engage and empower patients and families to help and support the journey to safer health care.

4

Ensure a constant flow of information and knowledge to drive the mitigation of risk, the reduction in levels of avoidable harm, and improvement in the safety of care.

6

Make zero avoidable harm to patients a state of mind and a rule of engagement in the planning and delivery of health care everywhere.

3

Assure the safety of every clinical process.

5

Inspire, educate and skill health workers to contribute to the design and delivery of safe care systems.

7

Develop and sustain multi sectoral and multinational synergy, solidarity and partnership to improve patient safety.

Alignment of Patient Safety with the Sustainable Development Goals (SDGs) 6 out 17

SDG	Target	How patient safety contributes
SDG 1 No Poverty	By 2030, reduce at least by half the proportion of men, women and children of all ages in poverty in all its dimensions according to national definitions.	Catastrophic health care expenditure pushes millions of families every year below the poverty line. Patient safety helps in reducing such incidents as well as leaving more finances to cover the cost of care for those who cannot afford it.
SDG 3 Good Health & Well-Being	By 2030, reduce the global maternal mortality to less than 70 per 100,000 live births	Many of maternal deaths are because of unsafe care in health care facilities
- W ◆	Achieve universal access health coverage, including financial risk protection, access to quality essential health-care services	Improving patient safety could drastically reduce the wastes in health care as well improve the access by positively influencing health seeking behavior
SDG 6	By 2030, achieve universal and equitable access to safe and affordable drinking water for all	Water and sanitation in health care facilities is a key component of patient safety. WASH facilities in health care facilities could influence sanitation behaviour of the community
SDG 8 Decent Work and Economic Growth	Protect labour rights and promote safe and secure working environment for all workers	Focusing on human factors and safety culture could sustainably improve workplace safety in health care settings, which is a major employer in most of the economies
SDG 10 Reduced Inequalities	By 2030 Empower and promote the social, economic and political inclusion of all	Empowerment and engagement of patients, families and communities is the cornerstone of patient safety, and promotes equity and inclusiveness in health care
SDG 12 Responsible consumption and production	By 2020 Environmentally sound management of chemical and all the wastes. In accordance to with agreed international framework	Patient safety programmes promote proper infectious waste management and "Mercury free hospitals" as per Minamata convention



the three leadership facts to sustain quality and patient safety improvement

- 1. Efficient and effective operating system
- 2. Supportive management infrastructure

• 3. Deep-rooted learning Organization

Health and Safety Executive (HSE)







HSE 6 commitments

- Empower and Engage Patients to Improve Patient Safety
- Empower Staff to Improve Patient Safety
- Anticipate and Respond to risks to Patient Safety
- Reduce Common Causes of Harm
- Measure and Learn to Improve Patient Safety
- Provide effective Leadership and Governance to Improve Patient Safety







Patient Safety Improvement Priorities:

Reducing
Healthcare
Associated Infection
and Antimicrobial
Resistance

Recognition and Response to Clinically Deteriorating Patients

Improving
Safety for those
with Disabilities
and Mental
Health Needs⁵

Reducing Medication Related Harm

Reducing the Risk of Harm from Falls Recognising,
Reducing and
Managing Venous
Thromboembolism
(VTE)

Safeguarding Vulnerable Patients

Ensuring Safe
Practices of Care
within High Risk
Environments⁶

Reducing and Managing Sepsis

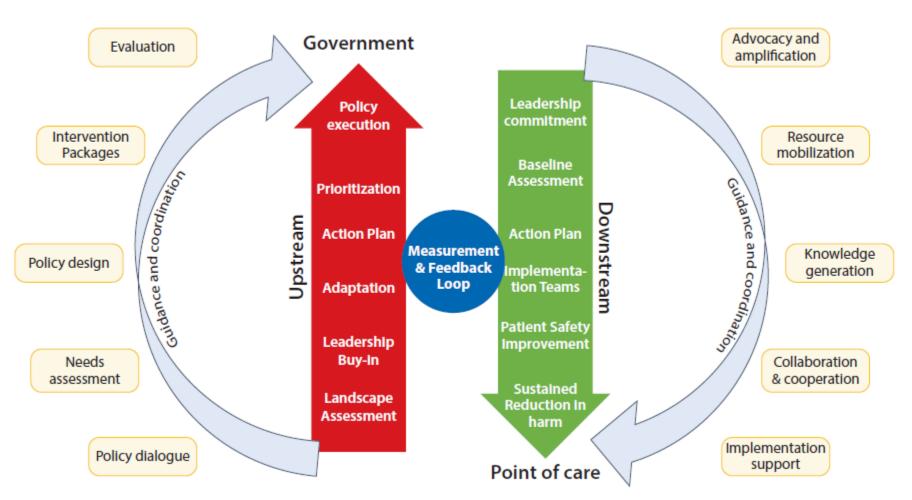
Prevention and Management of Pressure Ulcers

Improving Safety at Transitions of Care including Clinical Handover Prevention of Violence, Harassment and Aggression

Reducing the Number of Preventable Birth Injuries in Babies



The Patient Safety Implementation Ecosystem





Strategic direction

AHF VISION

- Supporting those who work in the health system to deliver safer patient care
- Improving data and information for safer health care
- Involving consumers in improving health care safety
- Redesigning systems of health care to facilitate a culture of safety
- Building awareness and understanding of health care safety





For sustainable change with the overall aim of providing health care that is safe

- commitment to consistency and alignment
- best practice implementation of governance
- national standardization in clinical improvement areas
- investment in operational capacity
- a culture that is open to learning from errors and adverse events
- a health services research agenda for patient safety



AHF VISION





Key aims of safety and quality improvement in health care

- Health care systems must be people-centred
- Systematic safety and quality improvement requires valid measurement and transparent reporting of performance
- Effecting and sustaining safety and quality improvement requires intentional initiatives at the policy, managerial and clinical levels



AHF VISION





Supportive Management Infrastructure

- putting the right people in the right jobs to drive change;
- clearly defining key metrics and accountability;
- cascading performance dialogue;
- clearly defining roles;
- frequently measuring and widely sharing operational metrics;
 AHF VISION







Why Sustainability Matters

Establishing infrastructure for safety and quality improvement at the local, jurisdictional and national levels will enable sustainability:

- A National Patient Safety Research Centre
- A National Centre for Patient Safety Improvement
- System capacity building
- Accreditation and standard setting mechanisms







modules for a national patient safety plan







Why Sustainability Matters



- Sustainability in health care occurs:
 - when a new safety innovation loses its separate identity as a project and becomes embedded into daily work flow
 - when hospital staff and providers share their expertise and provide ongoing support to others in carrying out the change package, which is now no longer described as change, but rather as "this is how we do things here."







1. Leadership Commits to Bold Improvement Goals

 The most important driver to sustaining and spreading new safety practices is public, active commitment of organizational leadership to achieving a bold improvement goal.







2. The Organization Has a Culture of Safety

 All levels of the organization demonstrate a commitment to safety in how they orient their staff and publicly monitor avoidable healthcare-associated conditions







3. Program Champions Motivate Individuals To Continue To Improve

 Effective champions are able to explain the importance of the change initiative, motivate others to embrace it, and, when necessary, overcome the skepticism and resistance of project opposers.







4. Interdisciplinary Teams Create and Sustain Effective Safety Practices

 Multidisciplinary teams are appropriate when care processes are complex and involve members of different professions involved in different actions for a medical procedure.







5. Staff Learn Both Technical and Adaptive Interventions

 A useful, generic model for addressing any safety concerns is to first translate the evidence into practice to improve patient care.







6. Frontline Staff Are Empowered To Raise Safety Concerns

 Leaders and managers empower staff, patients, and family members when they listen and respond to safety concerns and when they consider suggestions for improving current practices.







7. Key Outcomes Are Continuously Monitored and Communicated

 An increasingly common practice is for nursing units to post performance indicator boards that display unit safety aims and progress toward meeting or maintaining them.







8. Success Is Communicated and Rewarded

 Effective leaders and managers should always acknowledge unit teams that achieve safety goals or significant progress toward them.







9. Change Is Incorporated Into Daily Work Flow

 Spread and sustainability of prevention initiatives are fostered when the new units are able to make local adaptations based on the changes suggested by the consensus of the multidisciplinary teams.







10. The Facility Is a Learning Organization

 Safe patient care is based on continuous learning, from learning from defects, and keeping abreast of the most recent guidelines from professional associations, national patient safety and quality improvement organizations.





