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THE AWARE CONSUMER

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World Patient Safety Day 2023

Theme: Engaging Patients for Patient Safety

The AWARE CONSUMER proudly celebrates its 100th EDITION

– A journey of spreading awareness and igniting minds!

IN FOCUS
Patient Engagement: Fostering a Partnership Culture for Safe Healthcare

INTERVIEW
DR. ATUL MOHAN KOCHHAR
CHIEF EXECUTIVE OFFICER
NABH

GOVERNMENT PERSPECTIVE
Accreditation of Healthcare Providers in India

DR. RAVI P. SINGH
SECRETARY GENERAL
QUALITY COUNCIL OF INDIA

MESSAGE
SHRI JAXAY SHAH
CHAIRMAN
QUALITY COUNCIL OF INDIA

PLUS ROUND UP • RESEARCH FEATURE • MY MARKET

NATIONAL ACCREDITATION BOARD FOR TESTING AND CALIBRATION LABORATORIES

Mr. N VENKATESWARAN
CEO, NABL

NABL as an accreditation body complies to ISO/IEC 17011: 2017 and is a full member (signatory) to Asia Pacific Accreditation Cooperation (APAC) and International Laboratory Accreditation Cooperation (ILAC) Mutual Recognition Arrangements (MRA).

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- Cytopathology
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- Cytogenetics
- Molecular Testing

Important Accreditation Documents
(Available on NABL website - www.nabl-india.org)

-NABL 100A
General Information Brochure

-NABL 100B
Accreditation Process & Procedure

-NABL 112
Specific Criteria for Accreditation of Medical Laboratories

-NABL-153
Application Form for Medical Testing Laboratories

National Accreditation Board for Testing and Calibration Laboratories (NABL)
NABL House
Plot No. 45, Sector 44
Gurugram, Haryana - 122003
Email: info@nabl.qcin.org | Ph: 0124 4679700

Online application link:
https://nablwp.qci.org.in

Link for Accredited Lab Search:
https://nabl-india.org/nabl/index.php?c=searchlab&m=index&Itemid=177

VIEWPOINT

MESSAGE FROM PUBLISHER & EDITOR

Putting Patient Safety First!

PEOPLE SEEK MEDICAL treatment to recover from an illness or injury. The basic expectation is to improve one's well-being and become hale and hearty once again. But, what if the healthcare provider itself ends up endangering their health even further?

Indeed, errors, injuries, accidents and infections in healthcare settings are much more common than we expect! These can often lead to serious consequences. According to the World Health Organization (WHO) 2019 estimates, nearly 134 million adverse events take place during hospitalisation annually in low- and middle-income countries, resulting in 2.6 million deaths. In high-income countries, approximately 1 in 10 patients is harmed while receiving hospital care.

This is not to say that doctors or hospitals do not take their responsibilities seriously or intend to harm the patients. They are dedicated to delivering positive health outcomes even in the most intense and challenging of situations. However, the fact remains that errors tend to creep in due to varied reasons….

The pressing need to prevent and minimise harm to patients during the course of their medical treatment was recognised as a global health priority by the WHO in 2019 when it declared 17th September as World Patient Safety Day. This is a call for global solidarity and concerted action to improve patient safety. Patient safety is also considered as a fundamental component for achieving the much-touted universal health coverage.

The high point here is that consumers should be able to trust the healthcare system to provide them with safe, high-quality care. For this, the healthcare providers have to take all feasible steps to protect patients from harm, including preventing medical mistakes and injuries. This involves everything from possessing the right skills and knowledge about handling patients to proper communication and engagement with them. It is only with such concerted efforts that the avoidable damages can be prevented!

Prof. Bejon Kumar Misra
Publisher & Editor
bejonmisra@theawareconsumer.in

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PRAFULL D. SHETH
Editorial Board Member

DESKTALK

EMPOWERING FOR PATIENT SAFETY AND WELL-BEING

TO ERR IS human! Nobody can be expected to be perfect or faultless all the time. All of us tend to make mistakes at one time or the other, and the intense stress/challenging environment of a hospital can increase the potential for unintentional errors. In fact, patient safety as a healthcare discipline has emerged out of the growing complexity of the healthcare systems.

However, it has also been estimated that nearly half of the adverse events that arise during healthcare interventions are preventable!

What is needed here is ensuring that the systems, processes and tasks are well-designed to reduce the scope of errors as much as possible. And this is where accreditation enters the picture.

The National Accreditation Board for Hospitals & Healthcare Providers (NABH) - a constituent board of the Quality Council of India - has been set up to establish and operate accreditation programmes for hospitals and other healthcare organisations with the objective of enhancing the health system, promoting continuous quality improvement and maintaining patient safety. The elements of the accreditation process guide the organisations on how to conduct their operations with a focus on patient safety.

Healthcare facilities that are accredited by NABH uphold the requisite standards that will cut down potential medication errors, system failures, etc. Therefore, it becomes a benchmark for upholding patient safety and quality medical care for the consumers in the constantly evolving healthcare environment.

This will potentially unfold a paradigm shift in delivering healthcare services by sensitising the healthcare community towards their rights and responsibilities! Meanwhile, as this year's theme for World Patient Safety Day, 'Engaging Patients for Patient Safety' suggests, we, the patients also have to become equal partners with the healthcare team in our care. This will raise the parameters of patient safety, patient satisfaction and health outcomes, thus benefiting the healthcare system as a whole!

INSIDE

THE AWARE CONSUMER SEPTEMBER 2023

REGULARS

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Owner, Printer, Publisher & Editor:
Prof. Bejon Kumar Misra

EDITORIAL CONSULTANTS
Prafull D. Sheth
Bina Jain
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DESIGNER: Galaxy; Yellow Palette
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WEB DESIGNER:
Ebrahim Bhanpurawala

MANAGER CIRCULATION
S. K. Venkatraman

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Okhla Phase II, New Delhi - 110020

AUDITOR
CA Sandeep Gupta

For any queries, please contact us at
bejonmisra@theawareconsumer.in
Phone: 9311044424

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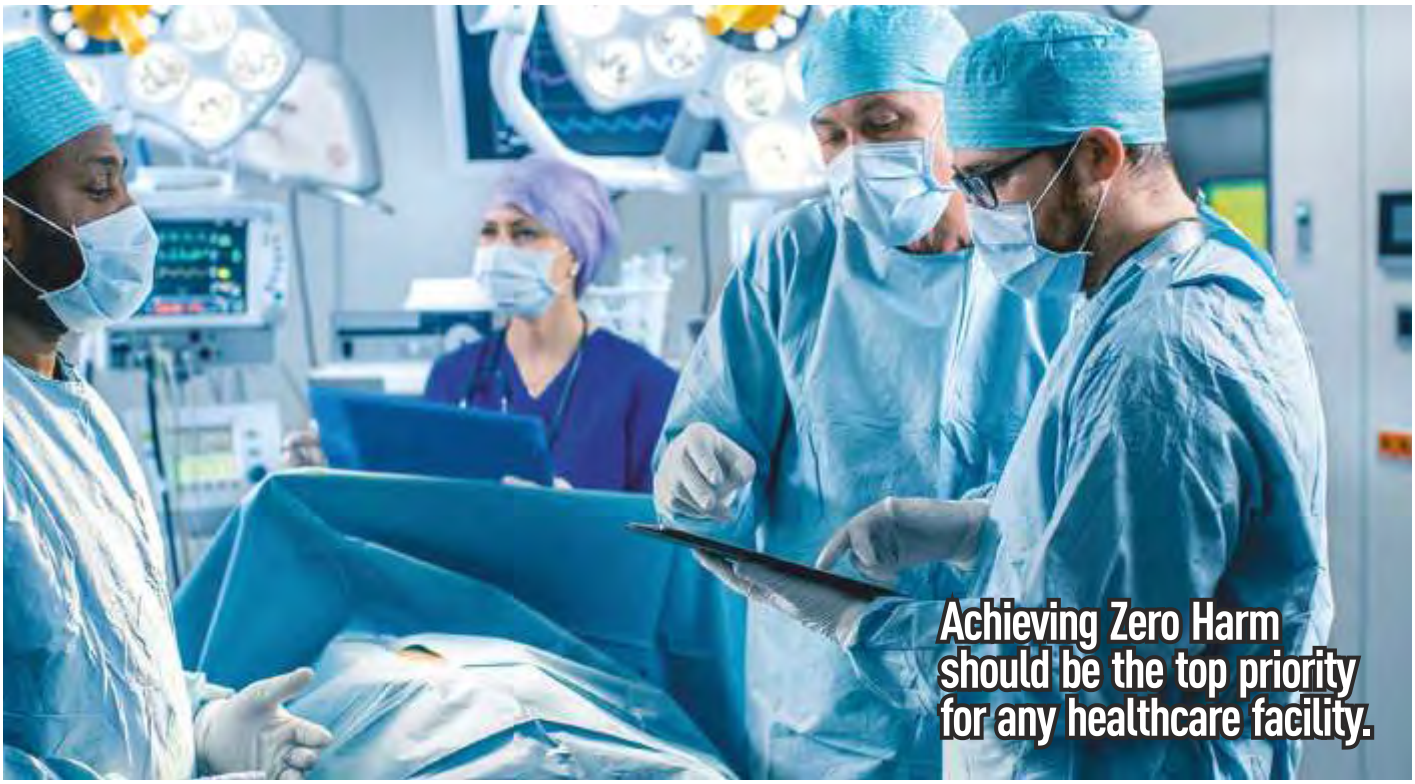
DR BHARATI PRAVIN PAWAR
MINISTER OF STATE (MoS) FOR HEALTH AND FAMILY WELFARE

India has always recognized the importance of patient safety and prioritized it as a public health issue. All of the MoS intiatives contribute to patient safety in their own way. Additionally, our culture and traditions also reflect and promote patient safety.

ROUNDUP



Zero Avoidable Harm to Patients – AIIMS Collaborates with WHO

INDIA'S PREMIER HEALTH institution - All India Institute of Medical Sciences, Delhi (AIIMS) - is collaborating with the World Health Organization (WHO-SEARO) to advance patient safety and quality control in healthcare. A core committee for Patient Safety and Quality is being constituted at AIIMS for implementation of advanced patient safety and quality initiatives across various departments. AIIMS will follow the learning curriculum proposed by WHO in collaboration with Duke-NUS (Institute of Patient Safety & Quality - IPSQ).

The curriculum comprises key components like:

- Sharing best practices by invited experts who are patient safety leads from various countries
- Visit to Singapore hospitals and facilities for cross-sharing of healthcare practices

DATA BRIEFING

As on 30th Sept. 2022, a total of 3415 public health facilities have achieved National Quality Certification.

- Patient safety and QI workshops to identify areas of improvement

An AIIMS official clarified, “AIIMS Director held a meeting with WHO and SEARO representatives to undertake patient safety and quality measures at the institute. Patient harm is one of the key global public health concerns which not just causes loss of healthy years of life, but also adversely impacts the financial, social and psychological well-being of patients. The plan is to start patient safety and quality control measures with the Department of Paediatrics including Neo-Natology and Paediatric Surgery including Neonatal Surgery."

A Patient Safety Secretariat will be created with the Department of Hospital Administration at AIIMS, New Delhi to implement the initiatives across the institute and eventually become a WHO Collaborating Center on patient safety. The WHO will organise onsite visits of experts or study tour of AIIMS staff as and when required.

Consumer Activists Intercept Shortcuts for Marketing Medicines

INDIA IS CONSIDERED the 'Pharmacy of the World'! However, attempts to cut corners by pharmaceutical companies lead to mishaps that tarnish this image of our country.

Recently, the makers of biosimilar genre of medicines have been batting for relaxation of conditions for marketing approval. In a hurry to capture the market, they are trying to skirt the prerequisites by coaxing the drug regulators to throw caution to the winds.

In July this year, they wrote letters to the secretaries of Union Health Ministry and Department of Biotechnology asking for waiving of conditions imposed by current Indian Biosimilar Guidelines (like mandatory animal studies and comparative safety and efficacy studies for marketing approval) and branded these conditions as a major barrier for 'Made in India' biosimilars trying to enter the market.

However, this is not sitting well with consumer activists who have categorically stated that patient safety cannot be traded for access and affordability!

Our editor and founder director of a patient safety foundation, **Prof. Bejon Kumar Misra** said, “Patient safety should be of paramount importance while approving pharmaceutical products in any market. Clinical trials and safety efficacy studies are vital requisites to ensure products launched in the market are safe and efficacious. The safety of patients cannot be compromised for the sake of affordability. There is no denying that biosimilars can significantly bring down the price of essential biologics that are used for critical diseases including cancer, but that does not mean biosimilars are allowed without adequate safety studies.”

Indeed, the safety question should be off-limits for any kind of compromise. Relaxations in the current regulations will not only put Indian patients at a huge risk, but also batter India's reputation on the global map!

NEED TO STRENGTHEN OVERSIGHT ON SPURIOUS DRUGS WITH DRUG REGULATION

INDIA HAS GAINED recognition for producing high-quality medicines at affordable prices for global consumers. However, substandard drug incidents continue to pop up time and again, resulting in a significant public health concern in different parts of the world.

There have been a series of alarming revelations about cough syrups exported by India around the world. In July this year, an Indian cold medication sold in Iraq was found to be tainted with toxic chemicals, 21 times the accepted limit. The World Health Organization (WHO) issued a substandard medicine alert for the same, making it the fifth such warning for India-made drugs in the past 10 months. The UN health body even issued a detailed advisory to regulatory authorities and the public as a precautionary measure.

Just prior to this, in June, the WHO - while investigating the global distribution of contaminated cough syrups – identified seven Indian-manufactured products as a cause for concern.

It should be noted that in November 2022, Indian cough syrups (containing the same dangerous compounds found in Iraq) were linked to the mass deaths of children in Gambia and Uzbekistan. More recently, the US Food and Drug Administration (FDA) issued a warning advising consumers against the use of a specific brand of eye drops (manufactured in India) due to potential bacterial contamination.

While serious questions are being raised about the quality of drug exports from India, in most cases, both India's health ministry and the drug regulator, Central Drugs Standard Control Organisation (CDSCO) refute the allegations even before investigations can take place, stating that the country follows a zero-tolerance policy on the production and distribution of counterfeit medicines. The crackdown on manufacturers involved in the production of spurious medicines is considered belated which should be replaced by a proactive and robust approach.

Dr. Gopal Dabade, President of Drug Action Forum and Convener of All India Drug Action Network states, “The government cannot conceal itself behind denials. When the World Health Organization (WHO) acknowledges problems, the government must turn its gaze inward instead of shifting blame onto others. The government needs to take a look at its regulatory mechanism where we are lacking. Additionally, it is crucial to address the issue of political interference in the regulatory authority.”

Prof. Bejon Kumar Misra further elaborated, “I was a member of the Mashelkar Committee representing the patients and consumers. It was an immensely valuable report, and the committee's work was commendable. The committee was formed during the tenure of Atal Bihari Vajpayee. Our primary objective was to ensure that individuals who produce counterfeit drugs and endanger the lives of citizens should face severe consequences. We advocated for the imposition of the death penalty on such criminals due to the significant public health concerns caused by their actions. Unfortunately, subsequent governments failed to implement this recommendation. It is disheartening to witness important reports and recommendations like ours being neglected and left untouched. These reports are packed with valuable information, and it saddens me to think about the resources invested in this process when they are simply disregarded. It brings tears to our eyes. The current administration has undertaken various initiatives, but it is crucial to first address the loopholes in our regulatory system and rebuild citizens' trust in the drugs manufactured in India.” ◗

Can We Permit Operating of Pharmacies Without a Valid Degree?

IN JUNE 2023, the Jharkhand government granted permission for opening pharmacies in rural areas without registered pharmacists. Chief Minister Hemant Soren announced that those who are educated enough to read and write the name and composition of the medicine written on the boxes can start a medical store in the state. He stated that the rule of pharmacist degree was applicable when chemicals were mixed in the desired proportion to prepare medicines. Now, everything comes written on its wrapper and box in which medicine is packed.

The Pharmacy Council of India (PCI) was staggered by the announcement and has urged the Jharkhand government to recall its decision by invoking Section 42 of the Pharmacy Act, 'no person other than a registered pharmacist shall compound, prepare, mix or dispense any medicine on the prescription of the medical practitioner and whosoever contravenes it, is liable for a punishment for six months, or with fine not exceeding one thousand rupees or with both'.

PCI President, Dr. Montu Kumar Patel said, "Drugs and medical devices are essential and special commodities. Their handling by an unqualified person will ignite the possibility of misuse, irrational use and wrong dispensing and will be detrimental to public health".

Prof. BEJON KUMAR MISRA
@bejonmisra

Most unfortunate Poor patients treated like Guinea Pigs in #Jharkhand Hon'ble CM must talk about patient safety
The Pharmacist are qualified practitioners to deliver medication @safemedsindia can guide you with a #sustainable solution
@HemantSorenJMM
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Regulating AI Chatbots – Imperative to Patient Safety

ARTIFICIAL INTELLIGENCE CHAT generative tools like ChatGPT and Google's MedPaLM show great promise for the healthcare sector. The chatbots are being integrated with search engines to provide medical advice to the consumers.

The information delivered in the interactive, human-like conversation is highly convincing, but what if it turns out to be incorrect or inappropriate? Indeed, relying on them can be unsafe and harm patient well-being.

Therefore, new frameworks for patient safety need to be developed to ensure that the AI's accuracy, safety and clinical efficacy is demonstrated and approved by regulators. Medical experts are pushing for regulating them as medical devices to ensure patient safety in healthcare.

If a healthcare professional or facility has caused harm to you or your family during the course of a treatment – which can be attributed to an error or lack of adherence to patient safety standards – you can sue them for medical malpractice based on the patient safety issue!

There have been many landmark judgments by the courts in favour of the patients. However, limitless patience is required as the cases can drag on for years before reaching fruition.

SHRI JAXAY SHAH
Chairman - Quality Council of India

QUALITY COUNCIL® OF INDIA
QCI Creating an Ecosystem for Quality

MESSAGE

INDIA'S ACCREDITATION SYSTEM was ranked 5th globally earlier this year. At QCI and NABH, we consider this just the beginning of our journey to embed quality in the lives of every Indian. As India journeys towards Atmanirbharta in the Amrit Kaal, I believe that accreditation is important to ensure that our products and services are not just 'Made in India' but 'Made in India with Quality.' Quality shall be the driving force for achieving the goal of developed India and consumers' trust is only gained by delivering high quality. It is at the core of everything that QCI and NABH is doing right now.

The Indian healthcare landscape is rapidly changing. It would not be an overstatement to say that the country is undergoing a healthcare revolution. This rapid advancement can be attributed to the government's focus on providing quality yet affordable healthcare for all, health tech advancements, the success of telemedicine during pandemics, and rising investor interest. The best part about this progression is that Tier 2 and Tier 3 cities are at the forefront of this growth story.

Patient safety is increasingly being recognised globally in health care as a function of Universal Health Coverage (UHC). In India, there are numerous initiatives in the health sector that address various aspects of patient safety independently. Safety of patients during the provision of health services that are safe and of high quality is a prerequisite for strengthening health care systems and making progress towards effective universal health coverage (UHC) under Sustainable Development Goal 3.

Patient safety is an essential component of health care. It is one of the dimensions of care quality, along with accessibility, acceptability, effectiveness, efficiency, and people-centeredness. It encompasses both medical and non-medical domains, as well as patient safety issues caused by communication errors, patient management errors, and clinical performance errors.

Patient safety errors can be avoided by implementing quality assurance practises as well as new technology, continuing education for health care workers, and error reporting systems. It necessitates a multi-pronged approach aimed at establishing SOPs for patient handling, diagnosis, and treatment, as well as the adoption of hand hygiene and other universal precautions, the availability of checklists, the rational use of medicine, training of health care professionals, strengthening health care infrastructure, a hospital accreditation programme, and patient awareness generation.

The quality sector and patient safety are currently riding on a wave of positive impact that is indicative of a very positive turnaround in the healthcare industry. Patient safety is fundamental to delivering quality essential health services. Indeed, there is a clear consensus that quality health services across the world should be effective, safe and people-centred. In addition, to realize the benefits of quality health care, health services must be timely, equitable, integrated and efficient.

NABH-QCI today has become synonymous with being a healthcare boon for thousands of hospitals and healthcare providers aspiring to achieve high level quality standards for healthcare quality. It is extremely encouraging to see that the NABH has taken several initiatives that contribute in creation of an ecosystem for quality in healthcare.

I strongly believe that quality interventions at the grassroots will be pivotal towards Atmanirbhar and Viksit Bharat in this Amritkaal.

As we continue on our journey to improve the Quality of Life of India's 140 crore citizens, I want you all to take the lead and be the torchbearers of change. In this journey where we overcome multiple challenges, I believe that we will work together to uphold and further contribute to the legacy of QCI and NABH and create a connection with the grassroots to permeate the idea of Quality in the DNA of each and every citizen in every part of India.

The Hon. Prime Minister Mr. Narendra Modi has appointed Mr. Jaxay Shah, founder Chairman of Savvy Group and former Chairman of CREDAI, as the Chairman of the Quality Council of India (QCI) for a period of three years effective from 21st October 2022. Mr. Shah has been appointed based on his vast industry experience which shall contribute to further propelling the wheels of Quality, a legacy established by the former Chairpersons of QCI. In addition, he also holds the position of the Chairman of the ASSOCHAM Western Region Development Council and serves as the Advisor at the PharmEasy Accelerator Program, which offers 1 lakh+ medicine and health products.

Professor (Dr.) Mahesh Verma, Chairman - NABH

Enhancing Healthcare Quality and Patient Safety – The NABH Way!

Dr. Mahesh Verma also holds the post of Vice Chancellor of Guru Gobind Singh Indraprashtha University. Formerly, he was the Director and Principal of Maulana Azad Institute of Dental Sciences. He is a B. C. Roy Awardee (2007) and was also bestowed with the Padma Shri in 2014. He was named Health Personality of the Year for 2012 by FICCI.

AS WE MOVE forward under the umbrella of National Accreditation Board for Hospitals and Healthcare Providers (NABH), I am filled with optimism and excitement.

NABH has worked tirelessly to spread the message of quality throughout the country. It is evolving into a massive industry. We are continuously building our capacity and enhancing our capability to move further and higher. We are committed to deliver better with each passing day.

Continuous improvement in patient safety based on learning from errors and adverse events is a cornerstone of the healthcare discipline. The discipline has emerged and evolved as a result of the increasing complexity of healthcare systems and the rise in patient harm in healthcare facilities.

Patient safety is critical to providing high-quality essential health services. Indeed, there is broad agreement that quality healthcare should be effective, safe and people-centric around the world. Furthermore, for the benefits of quality healthcare to be realised, health services must be timely, equitable, integrated and efficient.

Clear policies, leadership capacity, data to drive safety improvements, skilled healthcare professionals and effective patient involvement in their care are all required to ensure the successful implementation of patient safety strategies.

The first principle of healthcare service is “first to do no harm”. Patients' safety during the delivery of safe and high-quality health services is a prerequisite for strengthening healthcare systems and progress towards effective universal health coverage (UHC).

The quality sector and patient safety are currently riding a wave of positive impact, indicating a significant improvement in the healthcare industry. NABH has today become synonymous with being a healthcare boon for thousands of hospitals and healthcare providers striving to meet high-level quality standards in healthcare.

The theme given by WHO for Patient Safety – “Engaging patients for patient safety” is only possible when the patients are educated, aware and understand the importance of good health. The responsibilities lie with the young population of our country, which needs to be nurtured and educated in a way to have quality in the daily activities which becomes a practice and not a limitation. The country needs to be aware and alert regarding health, malpractices, beliefs and disbeliefs.

The symbiotic association between industry and Quality Infrastructure bodies is the key pillar for the nation's economic growth. A robust quality infrastructure ensures that products, processes and services adhere to international quality standards, thus paving the path for the country's economic growth. It is now more important than ever to investigate changes in the healthcare industry and strengthen processes. The quality journey requires that you constantly retrospect, improve and move forward. The patient quality and safety framework is based on needs, new diseases and digital growth.

QCI Gunvatta Sankalp has been a trademark of future opportunities, coordinated and organised by QCI and all of its boards in Uttar Pradesh and Orissa. The meetings with renowned leaders and cadres resulted in a confirmation of collaboration and association with the government in a variety of sectors, including healthcare.

The NABH team is working tirelessly in the new standards and the revision of old standards. NABH has revised the standards for SHCO Accreditation – 3rd edition, Dental Accreditation – 2nd edition, Entry level certification of Dental Clinics – 1st edition, Allopathic Clinics Standards - 2nd edition and others too. The revised Allopathic Clinics standards also include the checklist for Dermatology Standards and Dialysis Standards. I am sure the new standards for Care Home accreditation – 1st edition and Stroke Care Centers certification – 1st edition will be a gamechanger in the healthcare quality and patient safety.

NABH has also begun digitising its processes, as well as many other collaborative and gamechanging initiatives that will eliminate bottlenecks and time lag issues. As we focus our efforts on the world's first Digital Health standards powered by NABH, I am confident that we will have a significant impact on the future of digital healthcare quality systems, putting both the Indian healthcare system and NABH at the forefront.

In today's technology and innovation driven world, "transformation brings change, and change brings value" is the only way to progress. It is also beneficial to reimagine and revitalise our own digital infrastructure.

It is critical to expand horizontally and take initiatives in order to reach the common man. As a national accreditation body for hospitals and healthcare providers, it is our responsibility to ensure that even the last man in the line in India is aware of, and able to afford and access, high-quality healthcare services.

The way our country battled COVID-19, it has now become more imperative to be more alert and focussed towards changing needs of health.

As we move forward, let us remember that quality and patient safety is a journey, not a destination. It is an ongoing process of learning, improvement and evolution. We are dedicatedly committed to the cause in mission mode!

#65YearsOfSuccess

65th Anniversary

Thank you to everyone who has helped make this possible.
We hope to continue serving you for many more years to come.

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QUALITY COUNCIL OF INDIA
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G20

NABH stands committed to achieving the key healthcare priorities of G-20 India Presidency!

DR. RAVI P. SINGH
Secretary General, Quality Council of India

Accreditation of Healthcare Providers in India

Accreditation of healthcare providers works as a systematic approach to do the right things as per the right procedure to the right patient at the right time to have the right outcome. In India, NABH is the apex national healthcare accreditation and quality improvement body, functioning at par with global benchmarks.

NABH standards focus on patient safety and quality of the delivery of services by the hospitals in the changing healthcare environment!

ACCREDITATION IN THE context of healthcare refers to the formal evaluation procedure by means of self-assessment and external peer review process used by healthcare organisations to accurately assess their level of performance in relation to established standards and to implement ways to improve the healthcare system continuously.

The National Accreditation Board for Hospitals & Healthcare Providers (NABH) is a constituent board of Quality Council of India, set up in 2005 to establish and operate an accreditation programme for healthcare organisations. The board is structured to cater to the much desired needs of the consumers and to set benchmarks for the progress of the health industry. The board, while being supported by all stakeholders including the industry, consumers and government, has full functional autonomy in its operations.

NABH is an institutional member of the International Society for Quality in Health Care (ISQua) as well as member of its Board and Accreditation Council. NABH standards for hospitals has been accredited by ISQua. The accreditation of NABH standard for hospitals authenticates that NABH standards are in consonance with the global benchmarks set by ISQua and thus hospitals accredited by NABH will have international recognition.

International Society for Quality in Health Care (ISQua) is an international body which grants approval to Accreditation Bodies in the area of healthcare as mark of equivalence of accreditation programme of member countries.

NABH is also one of the founder members of the newly emerging Asian Society for Quality in Healthcare (ASQua). This initiative is to strengthen the Asian representation at international level and improve the quality structure in healthcare.

Here's a look at some of the activities of NABH:

- NABH works very closely with the government and develops MoUs and partnerships with national governmental bodies such as Ministry of Health, AYUSH, National Health Authority, National Commission for Homeopathy, Indian Pharmacopoeia Commission (IPC), other governmental, non-governmental, corporate sand NGOs.
- NABH is an active member and part of the G-20 Health working group.
- NABH is also actively contributing to the works and initiatives that our Honourable Prime Minister has announced.
- NABH is closely working on the government initiative under the Ministry of Health and Family Welfare for Heal in India, Heal by India project.

Currently, NABH is offering around 25 accreditations, certification and empanelment programs for various types and maturity level of healthcare providers. The accreditation programs are for hospitals, small health care organizations/nursing homes, blood banks and transfusion services, oral substitution therapy (OST) centres and primary and secondary health centres. A couple of more programs such as medical imaging services, dental hospitals/centres, AYUSH hospitals are being developed.

NABH is the only accreditation body that has an accreditation system for Traditional Medicine worldwide. It has independent standards for Ayurveda, Yoga & Naturopathy, Unani, Siddha and Homoeopathy. The standards are designed to facilitate ease of understanding and implementation.

NABH aims at streamlining the entire operations of a hospital. During the accreditation process, the hospital is assessed on over 600 parameters - divided between patient centred standards and organisation centred standards. To comply with these standard elements, the hospital will need to have a process-driven approach in all aspects of hospital activities – from registration, admission, pre-surgery, peri-surgery and post-surgery protocols, discharge from the hospital to follow up with the hospital after discharge. This is not limited to the clinical aspectsalone. Even the governance aspects should be process driven - based on clear and transparent policies and protocols.

Around 1800 hospitals are accredited, certified or empanelled with NABH

Many government hospitals are accredited and certified under NABH including one of the units of AIIMS. AIIMS Nagpur was congratulated by the Prime Minister to become 1st of all the AIIMS to receive NABH certification. It is also a proud testament to NABH's relentless efforts in ensuring quality healthcare across the country. Nearly 400 government healthcare facilities are associated with NABH in various capacities.

The Government provides incentivisation by Insurance Regulatory Development of India (IRDA) to the hospitals which are certified/accredited under NABH. IRDA too issued a notification to the health entities to consider NABH Entry level accreditation for availing reimbursement benefits from the insurance providers.

NABH is broadcasting the Quality Connect Podcast series in YouTube and other social media platforms and is also working further to reach to the very grassroot level.

In the coming months, NABH has planned extensively to conduct a mega quality campaign for awareness and sensitisation among hospitals and general public about quality, patient safety, accreditation and certification processes in 2023. NABH is also conducting regular workshops, trainings and awareness programmes for the hospitals to spread awareness and train the hospitals for accreditation and certification processes so that they are not misled by external factors, consultancies and agencies.

The NABH Programme on Implementation (POI) is one of the very well-known and most pursued courses by the managers and leaders of hospitals, health administration students and other healthcare professionals.

Adopting the message and this year's theme of World Patient Safety Day, NABH is organizing a one-day education/interactive workshop - NABH Patient Safety Conference (NPSC) on 17th September. It has a well-knit structural program to learn and deep dive into all the aspects of patient safety. This will be a vibrant forum to exchange ideas and learn from the renowned leaders and experts.

Conclusion

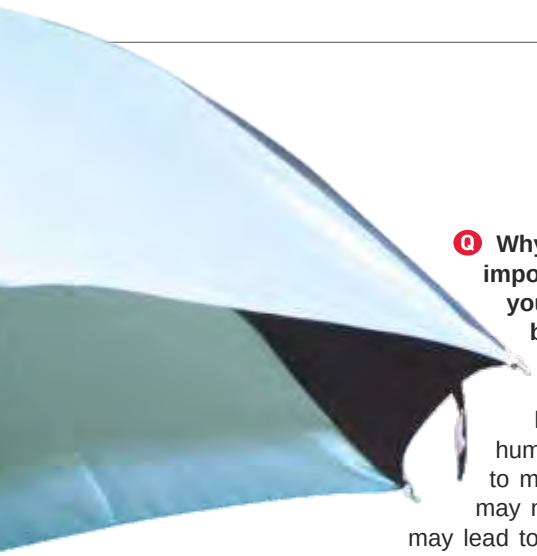
NABH has the mandate and remains committed to ensuring healthy lives and promoting wellbeing for all at all ages (SDG-3-Target 2030), creating a culture and an ecosystem of quality in healthcare taking Quality, Safety and Wellness to the last in the line. Over the years, successive NABH standards – including several homegrown Atmanirbhar NABH standards - have brought about paradigm shifts in the hospitals' approach towards delivering the healthcare services.

INTERVIEW

I stand for
Patient Safety

Dr. ATUL MOHAN KOCHHAR

Chief Executive Officer at NABH, is an active practicing clinician with a passion for quality in healthcare. He has received various state and national awards including the prestigious Sardari Lal Memorial Award for the year 2015. He is the current President of Society for Pediatric Dermatology and Founder Secretary of Scientific Cosmetological Society. He has more than 70 publications, 4 books and many chapters and multimedia to his credit. He has delivered more than 300 presentations at national and international conferences.



Q Why is patient safety important and why do you think it should be prioritised in healthcare?

"To err is human"– Being humans we are prone to make mistakes which may not be intentional but may lead to harm. Healthcare is such an industry which is driven by humans for humans. The ultimate beneficiary of cumulative efforts given by healthcare professionals is the patient. This is such an industry where man, materials and machines are dedicated towards one common aim – Patient Satisfaction.

As we emerge out of the shadows of the pandemic, it may do us good to pause, introspect and contemplate upon few of the key takeaways, that there is no absolute right/wrong. Even the developed countries suffered. We are as strong as the weakest link in the chain. We have to raise quality level uniformly. We need to go back to basics, example - hand hygiene, patient safety goals such as selecting the right patient for the right surgery at the right site, medication safety etc.

Ours is not one country, but 36 countries rolled into one. We are a united federal structure with a very big, diverse population which is economically, culturally and demographically different. This makes healthcare delivery all the more complex and health being a state subject lacks cohesive approach. Thus, it frames one of the important reason to have focus on Patient Safety.

According to the World Health Organisation, globally, as many as 4 out of 10 patients experience safety issues in primary and ambulatory care settings, 2.6 million people die annually due to unsafe care in hospitals, and medication errors are estimated to cost $42 billion each year.

Patient Safety is the most important aspect in the due course of treatment and stay of patients. But lately, it has been realised that there is requirement to create awareness to patients and by patients and thus, WHO has come up with the theme of World Patient Safety Day 2023 - "Engaging patients for patient safety".

Q How is NABH different?

The National Accreditation Board for Hospitals & Healthcare Providers which is commonly abbreviated as NABH is a constituent board of the Quality Council of India. It has been setup in 2005 to establish and operate accreditation programmes for hospitals and health care organisations with the objective of enhancing health system and promoting continuous quality improvement and patient safety.

The standards of NABH are framed in a manner which distinguish it from other accreditation programs:

- NABH Hospital Accreditation Standards are accredited by ISQua which gives the standards international recognition and the standards are benchmarked globally along with others.
- NABH is a constituent board of Quality Council of India which is an autonomous body under the Ministry of Commerce and Industry, Government of India.
- NABH is also supported by other ministries namely the Ministry of Health & Family Welfare, Ministry of Tourism, and others.
- NABH is the only accreditation body that has an accreditation system for Traditional Medicine worldwide. It has independent standards for Ayurveda, Yoga & Naturopathy, Unani, Siddha, and Homoeopathy.
- The standards are designed to facilitate ease of understanding and implementation.
- The cost of investment for NABH accreditation is much lower when compared to other international accreditation programs without compromising on the quality of standards.

Patients are the biggest beneficiaries of NABH accreditation:

- Patients are informed of the services provided by the organisation.
- Patients are assessed and treated with an appropriate care plan.
- Services are provided by appropriately credentialed and privileged healthcare professionals (medical, nursing, and other para-clinical professionals) to ensure patient safety in a safe environment.
- Patient care is uniform to all patients, continuous and multidisciplinary.
- Patients get a safe and organised medication process which is governed by written guidance.
- Safety is paramount and patients are continuously monitored to mitigate any medication errors and adverse drug reactions.
- National/international patient-safety goals/solutions are implemented.
- Patients are informed of their rights and educated about their responsibilities.
- Informed consent is obtained from the patient or family for providing care.
- Patients and families have a right to get information and education about their healthcare needs in a language and manner that is understood by them.

- Effective patient-centred communication is the motto of accreditation.
- Provides a safe and secure environment for patients, their families, staff and visitors.
- Patients and visitors are at reduced risk of healthcare-associated infections.

Healthcare organisation (HCO) and its personnel are also the beneficiaries of NABH accreditation:

- HCO through NABH accreditation demonstrates their commitment to providing safe, patient-centric and quality care.
- Quality of care through NABH accreditation increases patient satisfaction and thereby helps the HCO to build in community confidence.
- Governance within the organisation is professional, ethical and in compliance with all applicable regulations.
- Encourages an environment of patient safety and continuous quality improvement.

equitably and NABH is committed to help the Hon'ble Prime minister achieve this vision. There is a growing recognition of the importance of accreditation, as a useful tool for patient safety and more healthcare facilities are expected to seek accreditation in the coming years as patient expectations continue to rise and the healthcare system in India evolves.

Ensuring quality is a very critical component of high-performing health systems. There is a general awakening on this topic throughout the world, which has prompted the need to improve in terms of actual patient care and patient safety, the quality of healthcare. India has likewise embraced the cause to the fullest extent possible and is consistently committed to enhancing obtaining of accreditation through organisations like NABH.

Q What role does NABH play in developing patient safety in India?

NABH accreditations are focused towards ensuring patient safety through all ways and means which make the system process driven. The flow of information or

"It has been realised that there is requirement to create awareness to patients and by patients and thus, WHO has come up with the theme of World Patient Safety Day 2023 – Engaging patients for patient safety."

- Patientsafety and riskmanagement issues are an integral part of hospital management.
- Ongoing professional training/in-service education to enhance the competencies and skills of the staff continually which helps in the professional development of staff.
- Effective systems will be in place to prevent any adverse incidents and timely action for any sentinel events.
- Training of staff in all aspects of personal and patient safety during situations like CPR, emergencies during disasters, etc.
- The organisation promotes the physical and mental well-being of staff.

Overall, the dream of a self-reliant quality health system is only possible when high quality, affordable and accessible health services are being provided to all

work may be manual or through modern software, but the aim remains same - commitment to safe and complete care to patients which involves healthcare professionals, caregivers, non-technical staff and many more. NABH accreditation/certification standards are framed and timely revised which is in accordance with the industry best practices, standard guidelines which are nationally and internationally acclaimed. The exhaustive deliberations done while formulating standards is a result of brainstorming by healthcare industry's finest brains.

NABH - through various accreditation/certification and empanelment programs - brings out the standards and gives a framework of ensuring safe practices in any healthcare delivery. NABH, through accreditation, provides a framework that assists healthcare organisations in establishing objective systems intended for patient safety and quality care developed through a comprehensive approach to Total Quality Management, and has had a phenomenal impact on changing the healthcare landscape.

DR. ATUL MOHAN KOCHAR
CEO, NABH

#VaccinesWork

> Vaccines are amongst the greatest advances of modern medicine and help to keep families and communities safe. Whilst vaccines aren't a silver bullet, they will help us progress on a path to a world where we can be together again

The primary goal and objective of accreditation is to demonstrate that the healthcare organisation's dedication to accreditation standards leads to a higher level of performance and a stronger focus on patient care and to ensure that the healthcare organisations not only perform evidence-based practices but also give importance to access, affordability, efficiency, quality and effectiveness of healthcare. Accreditation also helps in branding the country internationally as a cost-effective quality healthcare hub for foreign patients and thereby, caters to medical tourism to a larger extent making it a favourable destination for healthcare.

Q What is your message to healthcare organisations on this World Patient Safety Day?

NABH is in its 18th year of creating an ecosystem of quality in healthcare and has built itself as a national accreditation body over the years. NABH is structured to cater to the needs of the consumers and sets standards and benchmark for the progress of the Indian Health Industry and provide a boost to Medical Tourism. NABH stands for its values: credibility, responsiveness, transparency and innovation in healthcare industry of the country and hence NABH accreditation is used as an empanelling criteria by various government organisations. NABH has given the country national healthcare standards or 'Desh ka Standard' and are in line with the vision of our Honourable Prime Minister of 'Atma Nirbhar Bharat'.Working together steadfastly,

NABH remains committed to ensuring healthy lives and promote wellbeing for all at all ages (SDG-3-Target 2030), creating a culture of quality in healthcare and taking Quality, Safety and Wellness to the last in the line.

Dr Punam Bajaj
Director
NABH

Putting Patient Safety at the Centre of DIGITAL HEALTH

While digital health technologies are being widely used to enable, improve and automate health services and have the potential to reduce patient safety incidents, it cannot be denied that the innovative tech solutions themselves can be the precursor of unintentional harm to the patients!

Digital health is an emerging issue in patient safety!

IT IS WIDELY acknowledged that health services and facilities are riddled with preventable errors. As digital health technologies become an everyday part of healthcare, the ongoing digital transformation of health systems is also enhancing safety of the patients. Health information technology itself is considered an important tool for reducing medication errors, adverse drug reactions, diagnostic errors and communication issues apart from improving compliance to practice guidelines. It is not just strengthening the recording and reporting systems, digital solutions can also assist in evidence generation and accelerate interventions, thus improving health, even to the extent of saving lives.

The WHO's Patient Safety Action Plan 2021-2030

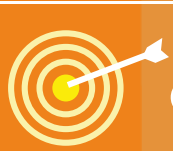
Vision, Mission and Goal

Vision

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

Mission

Drive forward policies, strategies and actions based on science, patient experience, system design and partnerships to eliminate all sources of avoidable risk and harm to patients and health workers



Goal

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

The WHO's Patient Safety Action Plan highlights the role of digital healthcare being an enabler to patient safety!

Health Technology at Play

Digitisation of patient records and the data infrastructure can be considered the initial transition to technological support in healthcare. Electronic files replacing manual documentation made the care process more consistent and reliable.

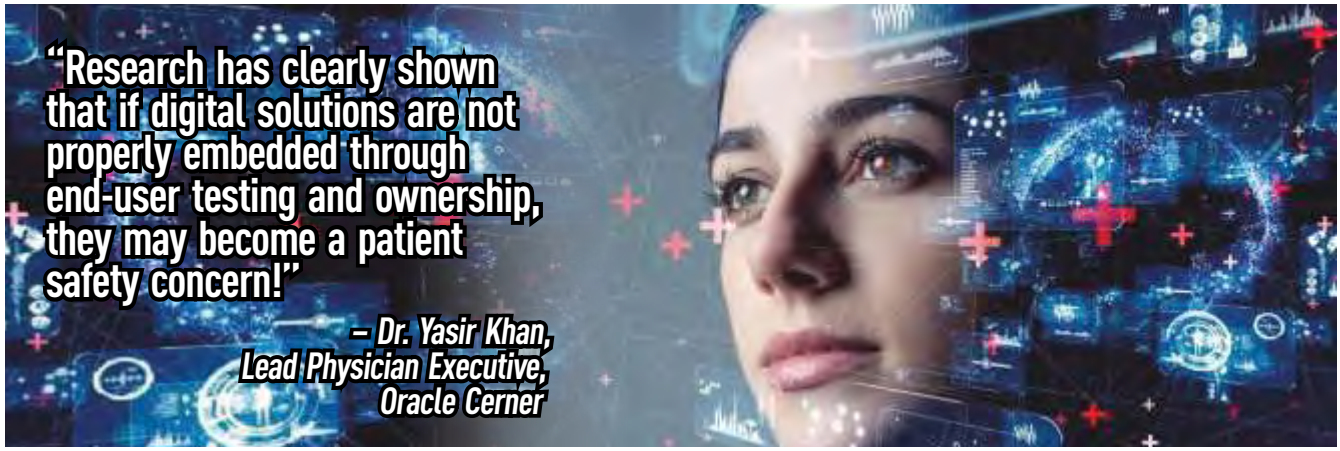
Telemedicine on virtual platforms and through apps on mobile phones has picked up at a phenomenal pace, fuelled by the need for social distancing during the COVID-19 pandemic. This has made healthcare more accessible and relevant too. It is now possible to connect people to health services in the most challenging of times.

Technology is assisting in gathering and synthesising patient information related to earlier health issues, treatments, reports and other critical data. This provides support in clinical decision making, making it more prompt, timely and accurate. At times, it even becomes possible to identify critical information from the extensive clinical data at hand, thus making healthcare more proactive and reducing the inherent risks.

Then there are tools to integrate evidence-based knowledge into care delivery that can substantially ameliorate threats to patient safety.

We are witnessing the advent of ubiquitous technologies which support remote monitoring and real-time self-care with even personalised and preventative dimensions. The wearable and other Internet of Things (IoT) medical devices are designed to monitor metrics and run diagnostics - from the extremely common fitness trackers and smart watches detecting biometrics like cardiac activity to continuous glucose monitors that can identify dangerously high glucose levels in diabetics. Not to mention sleep trackers, automated infusion pumps, remote blood pressure monitors and more.

As novel digital innovation continues at pace, new digital tools can be used both for monitoring and clinical decision making. Artificial intelligence has opened up a whole new vista that is not just limited to remote monitoring and management. Predictive models are revolutionising the way care is delivered – they can not only improve diagnosis, select appropriate treatments and detect early signs of deterioration, but also forecast health risks in the future, thus preventing adverse events and improving health outcomes.



The scale of change is unprecedented as complex algorithms can easily highlight abnormalities in lab results and capture vital signs upfront. While offering advice to physi-
cians and replacing some of the basic human activities right now, AI and IoT devices are on the cusp of taking decisions independently.

The Patient Safety Angle

It is clear that digital technology is extrinsically driving improvements in both the efficiency and safety of healthcare. However, what about the intrinsic safety of these technologies? Indeed, several threats to patient safety are cropping up that need to be addressed immediately.

Electronic health records increase the burden for staff and can lead to errors. Then there is the looming privacy, protection and consent concerns. At times, we are not even aware when and where our personal data is being collected, stored and analysed. The personal data can easily be hacked, leaked or infected with malware. The cyber threats call for increased security protocols and counter mechanisms to limit cybercrimes.

The software applications can prove to be unreliable and unsafe. There can be oversights in user-centred design or unanticipated malfunctions that translate into unintentional errors. At times, something as simple as lack of internet connection can become hazardous.

Hacking of medical implants and devices like insulin pumps or pacemakers can prove fatal for the patients. The hackers can even remotely interfere with X-ray data, CT scans, etc, not to mention the scope of bioterrorism.

"If we don't give enough attention to human factors, technology can introduce patient risk. Now, if we put the onus of using technology on the caregiver or patient, they may not have the same ability as a trained caregiver." – warns Priyanka Shah, senior project engineer at a device evaluation group

The AI algorithms again rely on existing data which are often fraught with errors. It also presents challenges surrounding safety, explainability and fairness.

Self-care backed by access to health metrics at home itself bring the veracity of the devices into question. What if the blood glucose test, blood pressure reading or ECG notification on a smartwatch is inaccurate or even misinterpreted by the patient/caregiver? This can lead to over/under medication which can prove to be damaging.

Ensuring Safe Care

It is evident that the full impact of digital health solutions has not been clearly studied or understood. Training, guidance and standards should underpin the safe use of digital technologies in the healthcare setting. The processes should be easy to follow with clear and accessible guidance.

Healthcare providers, staff and patients should be equipped and empowered through digital clinical safety training. The patients/caregivers need to be trained to purchase reliable medical devices as well as interpret readings from their smart sensors properly.

Needless to say, only evidence-based technologies and solutions should be allowed to enter the real world setting to avoid unanticipated consequences and adverse events. The regulators have to ensure that private companies provide secure technologies.

We need to establish policies, procedures and training to ensure patient data is protected. Even the IT departments have a responsibility to keep patients safe by employing and maintaining privacy and security mechanisms.

Conclusion

Patient safety is a moving target powered by new innovations in the digital health space. Therefore, the efforts to ensure safety of patients also need to evolve and modernise to pre-empt the new and emerging risks. Digital clinical safety has to become an inherent part of the healthcare culture. In fact, the promise of a safe health system in the future rests in digital clinical safety! ◗

Neeta Anand
Assistant Director
NABH

Why Consumers Should Look For NABH Accreditation

"Medical errors can occur in different healthcare settings, but those that happen in hospitals can have serious consequences. NABH accreditation works like a seal of security against inadvertent risks to patient safety."

– Neeta Anand

Studies have shown that accreditation improves the overall quality of care in healthcare facilities!

ACCREDITATION IS AN important approach towards improving the quality of healthcare organisations and serves as a guiding force to drive organisations to follow standardised procedures in order to ensure patient safety and quality by way of establishing systems and protocols leading to a culture that is safe and patient-centric.

The National Accreditation Board for Hospitals and Healthcare Providers (NABH) was established in the year 2005 for hospitals and healthcare organisations with an objective of enhancing the health system and promoting continuous quality improvement and patient safety. With the penetration in healthcare industry and contributions of stalwarts of quality, NABH received huge acceptance. In due course of time, NABH came up with other methodologies to operate accreditation, certification and empanelment programmes.

NABH has the mandate and remains committed to ensuring healthy lives and promote wellbeing for all at all ages (Sustainable Development Goals 3 - Target 2030), creating a culture and an ecosystem of quality in healthcare.

Benefits of Accreditation

The improvement of services for all stakeholders, including patients, the general public, hospitals and its staff is facilitated through accreditation. Accreditation of ahealthcare organisation is majorly patient-centric and aims to encourage patient safety as the overarching principle while providing care to patients. The clinical outcomes of a wide range of clinical conditions are improved through accreditation programmes, which enhance the process of care delivered by healthcare services. Achieving accreditation also requires holding staff to high standards for patient care.

The use of accreditation programmes as a strategy to raise the calibre of healthcare services should be encouraged.

The NABH Advantage

NABH, as an organisation, and NABH standards for hospitals are internationally recognised and benchmarked. The accreditation of NABH standard for hospitals authenticates that NABH standards are in consonance with the global benchmarks set by International Society for Quality in Healthcare (ISQua) and thus hospitals accredited by NABH will have international recognition.

NABH is the only organisation which conducts surveillance and surprise assessments after the healthcare organisation is accredited in order to maintain and ensure the continuity and sustainability of the quality system. NABH conducts surveillance assessment after 2 years of accreditation and surprise assessment as and when required, followed by renewal after 4 years (depending upon the program of NABH).

The benefits of having NABH accreditation is for all stakeholders, namely the healthcare organisation, its staff, third party insurance providers, but the most to the patients. A few of them have been mentioned below:

Benefits for Patients

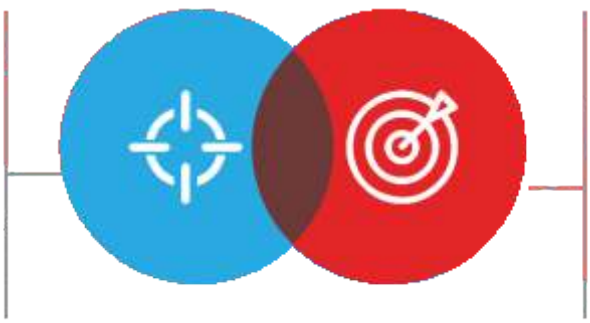
- Accreditation results in high quality of care and patient safety.
- The patients are serviced by credentialed medical, paramedical staff.
- Rights of patients are respected and protected. Patient's satisfaction is regularly evaluated.
- Patients have the right to raise a complaint.
- Patients' feedback is monitored for continuous improvement.
- Audits (Clinical & Managerial), Quality Indicators (Clinical & Managerial) mandated by NABH help bring the shortcomings to light and thus improve them.
- Services provided to patients are guided by Standard Operating Procedures and Policies.
- Clinical care is guided by technical and registered professionals.
- The quality of outsourced services are monitored.
- The services are guided as per law of the land.

Benefits for Organisations

- Accreditation of a healthcare organisation stimulates continuous improvement.
- It enables the organisation in demonstrating commitment to quality care and patient safety, thereby ensuring best clinical outcomes.
- It raises community confidence in the services provided by the healthcare

Vision

To be apex national healthcare accreditation and quality improvement body, functioning at par with global benchmarks



Mission

To operate accreditation and allied programs in collaboration with stakeholders focusing on patient safety and quality of healthcare based upon national/international standards, through process of self and external evaluation

NABH accreditation is a recognition that a healthcare organisation has met the national standards of quality and patient safety. It covers various aspects of healthcare delivery, including patient rights and education, infection control, infrastructure and facilities, clinical care, and safety management.

organisation as services are provided by credentialed medical staff.

- It also provides opportunity to healthcare unit to benchmark with the best.
- An accreditation status is a marketing advantage in a competitive healthcare environment.
- The HCO standards having been certified by ISQua gives an international recognition which will also help promote medical tourism.
- It provides an objective system of empanelment by insurance and other third parties.

Benefits for Staff

- The staff in an accredited hospital is satisfied as it provides opportunity for continuous learning, good working environment and leadership.
- Efficiencies and competencies of staff also gets improved in an accredited hospital.
- It improves overall professional development, knowledge and competencies in systematic ways with defined ownership and accountability of all the staff including medical and para medical staff.

Benefits to Paying and Regulatory Bodies

- Accreditation provides an objective system of empanelment by insurance and other third parties.
- Accreditation provides access to reliable and certified information on facilities, infrastructure and level of care.

Conclusion

Today NABH is the largest healthcare provider accreditation body in our country with more than 18,000 healthcare organisations partnering with NABH under various accreditation, certification and empanelment programs.
As mentioned above, the standards of NABH are framed in such a way to ensure patients as the biggest beneficiary of NABH accreditation amongst all the stakeholders. ◗

Prioritising Patient Safety in Healthcare

No healthcare provider wants a patient to experience harm during treatment. However, is this a priority of healthcare? The World Patient Safety Day is a campaign for all stakeholders in the healthcare system to work together and share engagement to improve patient safety. It is galvanising global actions for safer systems, services, procedures and practices in healthcare to eliminate harms to patients while also mitigating any risk to the health workers.

A day dedicated to the safety of the patient!

THE FUNDAMENTAL PRINCIPLE of contemporary medicine is 'First Do No Harm'. This is enshrined in the Hippocratic Oath – the rite of passage for every healthcare provider before they officially step into the world of medicine.

Alas, adverse events during treatment often end up endangering patient safety. Recognizing that healthcare errors impact 1 in every 10 patients around the world, the World Health Organization (WHO) termed patient safety as an endemic concern.

The current challenge in global public health is patient harm, which is a leading cause of avoidable mortality and morbidity! - WHO

There are many compelling reasons to scale up interventions for reducing patient safety incidents. Unsafe care can lead to:

- Patient dissatisfaction
- Increased costs
- Loss of trust
- Loss of life
- Demotivated healthcare providers
- Increased waste and inefficiency

It has been estimated that focusing on avoiding preventable healthcare errors can save up to 15% of healthcare costs

WHO Initiatives

WHO first started working on patient safety with the launch of the World Alliance for Patient Safety in 2004. The work has evolved over time, gradually facilitating improvements in the safety of health care within Member States.

The Patient Safety and Risk Management unit at WHO has been instrumental in advancing and shaping the patient safety agenda globally by focusing on driving improvements in some key strategic areas through:

- providing global leadership and fostering collaboration between Member States and relevant stakeholders
- setting global priorities for action
- developing guidelines and tools
- providing technical support and building capacity of Member States
- engaging patients and families for safer healthcare
- monitoring improvements in patient safety
- conducting research in the area

Different Global Patient Safety Challenges were established to identify specific patient safety burdens that pose a major and significant risk. They include:

- Clean Care is Safer Care (2005) - To reduce healthcare-associated infection, by focusing on improved hand hygiene
- Safe Surgery Saves Lives (2008) - To reduce risks associated with surgery
- Medication Without Harm (2017) – To reduce the level of severe, avoidable harm related to medications globally by 50% over five years.

WHO has been instrumental in the creation of the Global Patient Safety Network and the Global Patient Safety Collaborative - networking and collaborative initiatives that promote global solidarity.

The apex health organisation also provided strategic guidance and leadership to countries through the annual Global Ministerial Summits on Patient Safety (pioneered in 2016), which seek to advance the patient safety agenda at the political leadership level with the support of health ministers, high-level delegates, experts and representatives from international organisations.

World Patient Safety Day

Following a successful series of the summits, the 72nd World Health Assembly adopted the resolution WHA72.6 – 'Global Action on Patient Safety' in 2019 recognising patient safety as a global health priority and endorsed the establishment of World Patient Safety Day, to be marked annually on 17th September.

World Patient Safety Day is one of WHO's 11 global public health campaigns. Its objectives are to increase public awareness and engagement, enhance global understanding, and work towards global solidarity and action by Member States to enhance patient safety and reduce patient harm. This serves as an opportunity for providers, seekers and managers of healthcare services to join a platform and express solidarity and compassion to make healthcare safer. The Day basically calls on all countries and international partners for solid action towards patient safety.

World Patient Safety Day is a campaign for all stakeholders in the healthcare system - patients, families, caregivers, health workers, healthcare leaders and policymakers - to work together and share engagement to improve patient safety. A new theme is highlighted every year as a priority patient safety area where urgent action is needed to reduce avoidable harm in healthcare and achieve universal health coverage.

2019: Patient Safety: A Global Health Priority – To promote open communication for learning from errors and to emphasise the importance of everyone's voice in prioritising patient safety. The slogan was 'Speak Up for Patient Safety!'

2020: Health Worker Safety: A Priority for Patient Safety – To focus on the interrelationship between health worker safety and patient safety, emphasising the need for a safe working environment for health workers as a prerequisite for ensuring patient safety. The slogan was 'Safe Health Workers, Safe Patients'.

2021: Safe and Respectful Maternal and Newborn Care – To spotlight the need to address safety in maternal and newborn care, particularly around the time of childbirth. The slogan was 'Act Now for Safe and Respectful Childbirth!'

2022: Medication Safety – To highlight the risk of medication errors and associated medication-related harm and recognise the complexity of medication-related harm prevention and reduction. The slogan was 'Medication Without Harm!'

2023: Engaging Patients For Patient Safety – To recognise the crucial role patients, families and caregivers play in the safety of healthcare. The slogan is 'Elevate the Voice of Patients!'

Patient and family engagement was embedded in the Resolution WHA72.6 as well as the Global Patient Safety Action Plan 2021-2030 as main strategies for moving towards eliminating avoidable harm in healthcare.

Objectives of World Patient Safety Day 2023

- Raise global awareness of the need for active engagement of patients and their families and caregivers in all settings and at all levels of healthcare to improve patient safety.
- Engage policymakers, healthcare leaders, health and care workers, patients' organisations, civil society and other stakeholders in efforts to engage patients and families in the policies and practices for safe healthcare.
- Empower patients and families to be actively involved in their own healthcare and in the improvement of safety of healthcare.
- Advocate urgent action on patient and family engagement, aligned with the Global Patient Safety Action Plan 2021–2030, to be taken by all partners.

A signature mark of the global World Patient Safety Day campaign is the lighting up of prominent monuments, landmarks and public places in the colour orange, in collaboration with local authorities, all around the world.

The colour orange symbolises the central role patient safety plays in the efforts to achieve universal health coverage.

International Patient Safety Goals (IPSG)

The Joint Commission International (JCI) – a recognised global leader in healthcare accreditation - introduced the IPSGs in 2006. These patient-centric goals aim to encourage specific improvements in patient safety by focusing on six key problematic areas identified by the Joint Commission on Accreditation of Healthcare Organisations (JCAHO). The 6 IPSGs are updated from time to time – done once in 2011 and again in 2017. JCI also recommends targeted solution tools to help hospitals meet the IPSG standards.

Healthcare providers can improve both patient safety and outcomes by focusing on these six key areas, engraining them in everyday practices and getting them working more safely.

The IPSGs are as follows:

Goal One: Identify Patients Correctly – The objective is two-fold:

- Confirm the identity of the patient for giving the service or treatment
- Match the service or treatment to that particular patient

JCI recommends using at least two identifiers - patient's name, date of birth, MRD/UHID No. or a barcoded wristband - before any procedure, surgery, medication administration, dispensing of medication or any other situation. Criteria such as room number or location should not be used. In case the patient's name is not known, they can be named Unknown 1, 2, 3 and so on and the UHID should be generated.

Goal Two: Improve Effective Communication – Timely, accurate, complete, unambiguous and well understood communication is crucial for reducing errors and improving patient safety. This kind of an effective communication system should be established both between healthcare providers and patients, and between healthcare providers themselves.

This is why verbal orders should not be allowed except in life threatening conditions. Moreover, it is recommended that verbal and telephone orders should be written down by the receiver and read back before being confirmed by the individual providing the information.

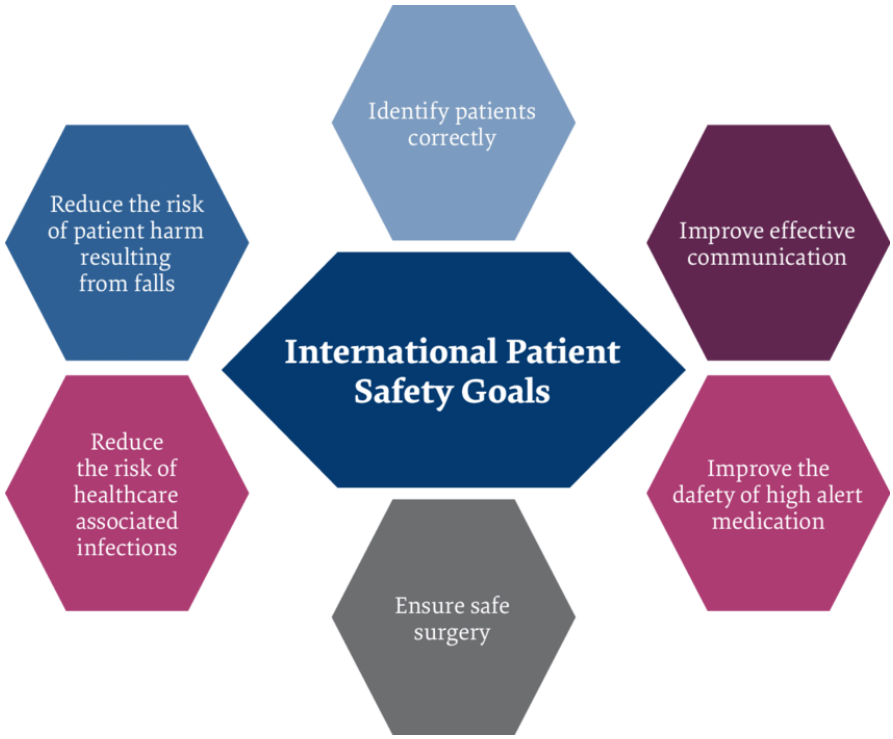
Goal Three: Improve the Safety of High-Alert Medications – While all medications can be dangerous when used inappropriately, High Alert Medications (HAMs) – like investigational medications, controlled medications, chemotherapy drugs, anticoagulants, psychotherapeutic medications and look-alike/sound-alike (LASA) medications - have a heavier risk of causing serious harm when they are used in error. To reduce the risk, adequate safety processes should be in place regarding the dispensing, storage, documentation, administration and monitoring of such high risk medications.

Goal Four: Ensure Safe Surgery – Surgeries are often performed at the wrong site, wrong procedure or on the wrong person, leading to adverse events. Multiple strategies and processes need to be instituted to ensure that surgeries are performed safely by identifying the correct patient, correct procedure and correct site – like using Surgical Safety Checklist, marking the site and ensuring that all necessary equipment and supplies are available, correct and functional.

Goal Five: Reduce the Risk of Health Care-Associated Infections – Healthcare associated infection (HAI) are those acquired by a patient in the healthcare setting itself while undergoing treatment. Effective infection prevention and control practices like evidence-based hand-hygiene guidelines (including washing and disinfection), environmental cleaning and appropriate use of personal protective equipment should be adopted and implemented across all personnel.

Goal Six: Reduce the Risk of Patient Harm Resulting from Falls – Patients can slip, trip or fall in both in-patient or out-patient settings leading to injuries. It is important to assess the risk of falls, especially in children and aged patients. Appropriate precautions have to be implemented to reduce the risk of such falls - like keeping the bed rails upright, using strap belts while transporting the patients on a wheel chair, placing fall caution board while mopping and using other patient care equipment.

India's NABH (which is considered the equivalent of JCI) also upholds the IPSGs to help accredited organisations address specific areas of concern in some of the most problematic areas of patient safety.



The six IPSGs promote specific improvements in patient safety to safeguard the patients from any risks. Compliance with IPSG in monitored in JCI-accredited hospitals since January 2006.

Conclusion

Concerted action is needed and is also ongoing to promote patient safety by bringing a studied focus on preventing and reducing risks, errors and harm that happen to patients during the provision of healthcare.

Sunday, 17th September, 2023 marks the fifth annual World Patient Safety Day. The global campaign for World Patient Safety Day 2023 has proposed a wide range of activities for all stakeholders around this landmark day, including national campaigns, policy forums, advocacy and technical events, capacity-building initiatives, etc.

Mr. Chandrakant Lahariya from the World Health Organization Country Office in India shared a few indicative approaches for patient safety:

- **A clean and safe environment - For example, if there are no wet floors or water spills on the floor, it can prevent falls of the patient (or relatives), which is emerging as a major patient safety issue. Provision of running water and soap for hand washing closer to patient wards can reduce infections.**
- **Simplify and standardise the treatment - The treatment protocols and standard treatment guidelines need to be widely made available and implementation facilitated.**
- **Training - Every facility should develop a plan for training of staff with provision of regular in-service training in patient safety.**
- **Involve patients in their own care – This could be innovative such as patients marking their body part which needs to be operated and seeking their regular feedback before discharge.**
- **A culture of reporting - Discussing and learning from mistakes needs to be developed at facilities.**

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Awareness and Understanding Among Patients About Patient Safety in India

Patient safety is fundamental to delivering quality health services. Unsafe care undermines every goal of modern healthcare systems. Patients form a cornerstone of patient safety - if they are involved at a basic level by sharing their observation, the burden of harm can be reduced by 15%. Therefore, it is imperative to understand the awareness of patients about patient safety.

The occurrence of adverse events due to unsafe care is likely one of the 10 leading causes of death and disability in the world!

IT IS ESTIMATED that around 5.2 million injuries occur due to medical errors in India, resulting in around 3 million preventable deaths of healthcare consumers every year. An average of 12.7 adverse events occur for every 100 hospitalisations.

Industries with a perceived higher risk (like aviation and nuclear industries) have a much better safety record than healthcare. There is a 1 in 1,000,000 chance of a traveller being harmed while in an aircraft. In comparison, there is a 1 in 300 chance of a patient being harmed during healthcare!

Patient safety can be compromised in several ways. Here, it is imperative to understand the awareness of patients about patient safety. However, there is a dearth of studies on patients' perspectives about patient safety in India.

A group of leading doctors from KPC Medical College and Hospital (Department of Pharmacology) and Peerless Hospital and BK Roy Research Centre (Department of Clinical Research and Quality Assurance) in Kolkata conducted a study to gain insight into the awareness of Indian patients about patient safety and evaluate their willingness in promoting the same.

The cross-sectional questionnaire-based study by the clinical pharmacologists covered 800 urban patients over 18 years of age (both gender) who were admitted and discharged after treatment at Peerless Hospital and BK Roy Research Centre (a NABH-accredited tertiary care private hospital) between November 2020 and April 2021. It involved online interactive sessions pertaining to patient safety and patient safety culture. 635 patients agreed to participate in this study of which 385 (60.6%) were males.

The study was published in the Journal of Patient Safety and Risk Management in January 2022.

Comprising of 13 questions, the questionnaire was prepared according to ISQua and was prior validated in a pilot study involving 40 patients. The responses were analysed using descriptive statistics.

The patients were treated in departments like general medicine, general surgery, cardiology, pulmonology, orthopaedics, neurology, nephrology, gastroenterology, obstetrics and gynaecology, urology and cardiothoracic and vascular surgery. (see Figure 1) The mean duration of hospital stay was 5.1 ± 3.2 days.

As can be seen from Table 1, 93.4% of the patients were aware of the term 'patient safety', 99.4% felt that patient safety is very important and 78.3% agreed that patients play an important role in patient safety culture. (see Figure 2)

As many as 35.3% of the patients had faced situations where they felt that patient safety was compromised (see Figure 3). These patients had to stay longer at the hospital and complained of discomfort following the

Figure 1: Healthcare Department for Treatment

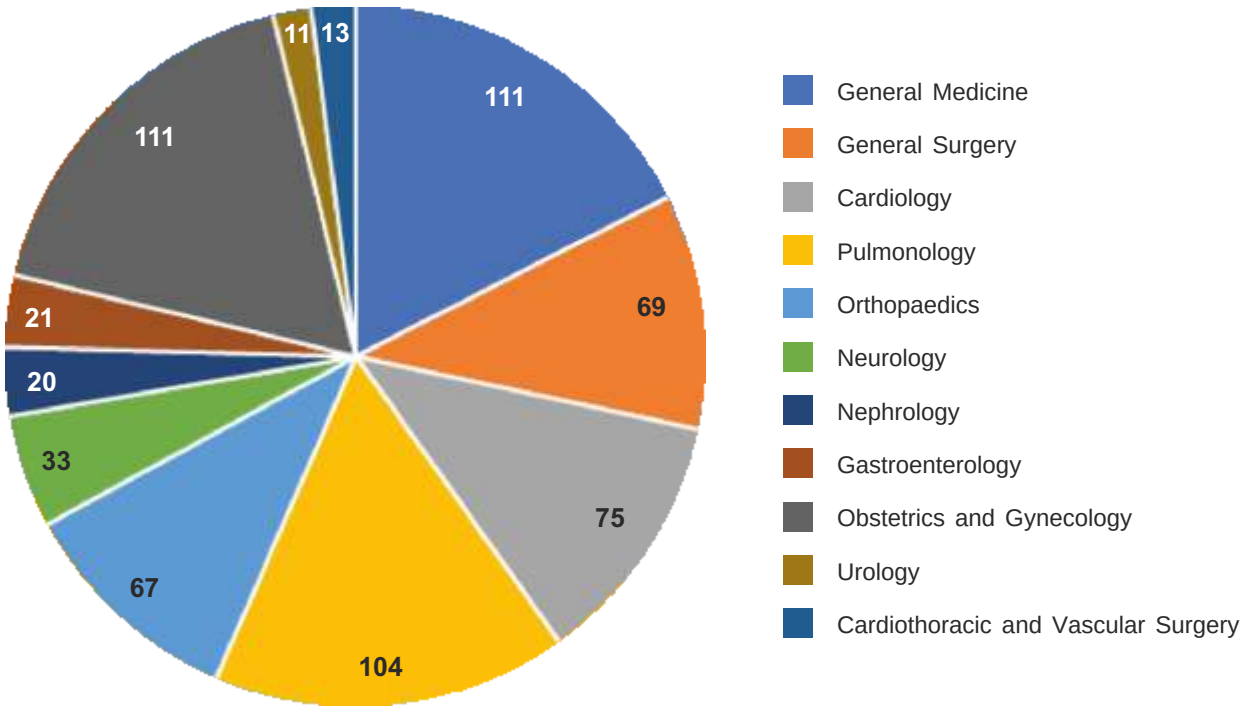


Table 1. Responses of the patients to questions on patient safety and patient safety culture (n = 635)

Sl. No.	Questions	Responses	n (%)
1	Are you aware of the term 'patient safety'?	Yes	593 (93.4%)
		No	17 (2.7%)
		May be	25 (3.9%)
2	How important is patient safety?	It is very important	631 (99.4%)
		Not that important	2 (0.3%)
		Not sure	2 (0.3%)
3	Do you agree that patients play a crucial role in patient safety culture?	Strongly disagree	38 (5.9%)
		Disagree	26 (4.1%)
		Neutral	74 (11.7%)
		Agree	280 (44.1%)
		Strongly agree	217 (34.2%)
4	An example of patient safety is	Reducing the risk of healthcare-associated infections	249 (39.2%)
		Careful use of high risk/alert medications	150 (23.6%)
		Accurate patient identification	87 (13.7%)
		All of the above	149 (23.5%)
5	Who plays the most important role in the safety of patients?	Doctors	276 (43.5%)
		Nurses	175 (27.6%)
		Pharmacists	32 (5.0%)
		Top management	152 (23.9%)
6	The basic requirements to develop safety in any hospital	Management commitment to safety	69 (10.9%)
		Adherence to safety guidelines	51 (8.0%)
		Reporting of errors/incidents	4 (0.6%)
		All of the above	511 (80.5%)
7	Have you ever been in a situation where you felt that patient safety was compromised?	Yes	224 (35.3%)
		No	309 (48.7%)
		Maybe	102 (16.0%)
8	If yes, what was your course of action?	Reported to the immediate higher authority	144 (64.3%)
		Ignored	42 (18.8%)
		Did not have any idea what to do	38 (5.9%)
9	What among the following do you think can lead to continuous improvement in patient safety culture	Actively doing things to improve patient safety	80 (12.6%)
		Converting any mistake/adverse event to a positive change in the system	36 (5.7%)
		Continuous monitoring of the effectiveness of the implemented patient safety strategies	47 (7.4%)
		All of the above	472 (74.3%)

Contd...

Sl. No.	Questions	Responses	n (%)
10	Have you participated in any patient safety program?	Yes	5 (0.8%)
		No	630 (99.2%)
11	Are you willing to participate in a patient safety program?	Yes	600 (94.5%)
		No	35 (5.5%)
12	Which one of the following factors do you consider is likely to influence your participation in safety-related behaviours?	Knowledge and belief about safety	350 (55.1%)
		Stage and severity of patient's illness	62 (9.7%)
		Healthcare professional's interaction with you	155 (24.4%)
		Type of healthcare setting	68 (10.8%)
13	What do you think will be the best way to increase awareness on patient safety culture?	Accessibility to information about care for patients	370 (58.3%)
		Motivation of individual patients	81 (12.8%)
		Giving importance to patients' opinion	127 (20.0%)
		Patient empowerment to take decisions in their treatment	57 (8.9%)
14	Key suggestions by patients to improve patient safety	Medical facilities to patients whenever needed (patient-first approach)	
		Improve patient communication skills	
		Be pro-active, enhance decision-making ability, take immediate actions	
		Assessment of hospital's current patient safety culture	

Figure 2: Do you agree that patients play a crucial role in patient safety culture?

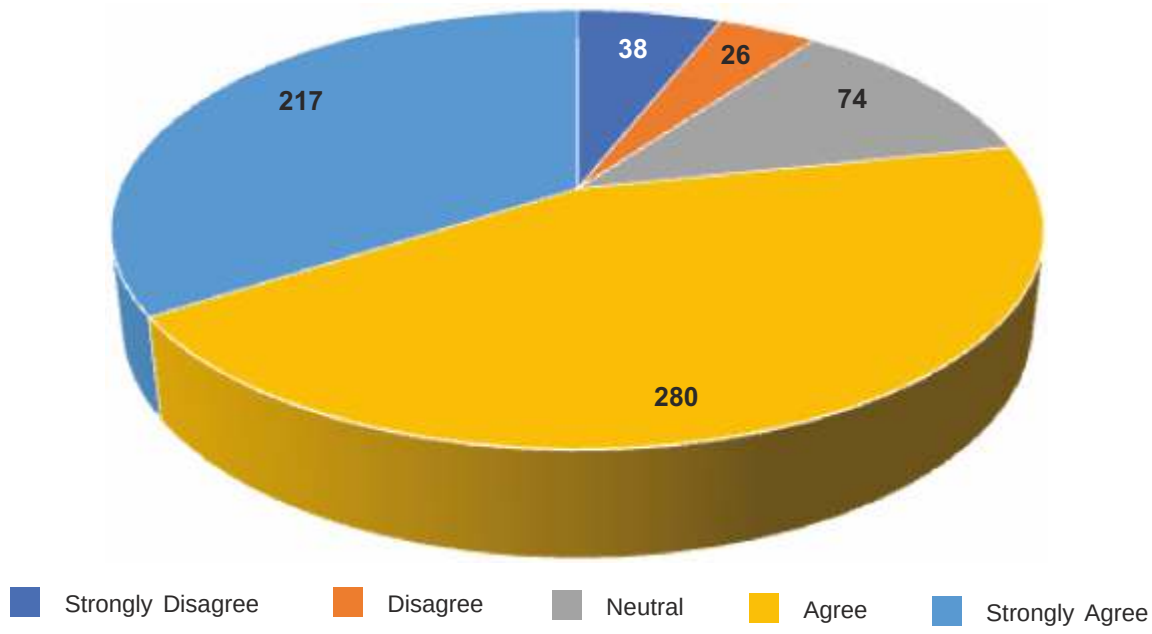
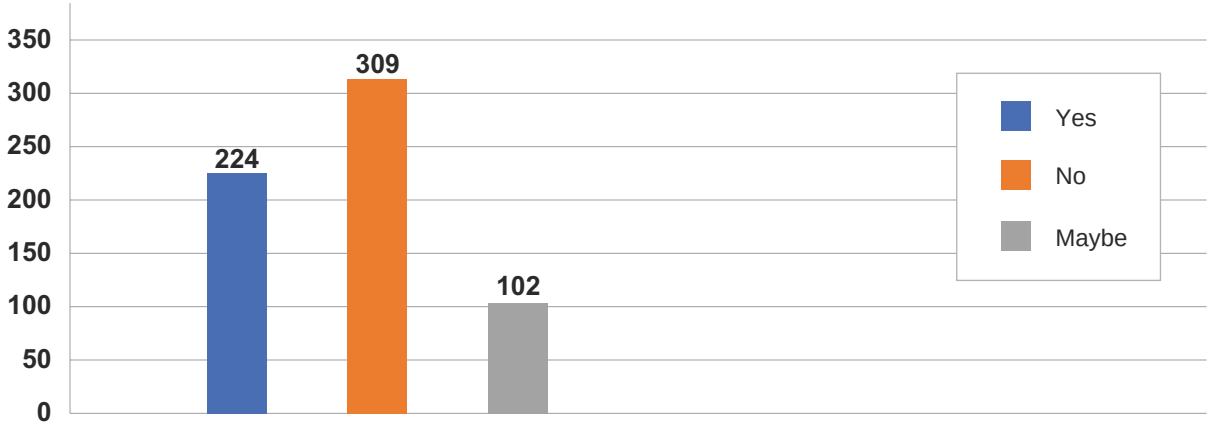


Figure 3: Have you ever been in a situation where you felt that patient safety was compromised?



administration of medications. Another, 64.3% reported to higher authorities when faced with such situations, while the remaining either ignored the issue or had no idea about how to deal with the same.

While 99.2% of the patients had never participated in any patient safety program, 94.5% of them were willing to participate in the same. Accessibility to information about patient care was deemed essential by 58.3% of the patients.

An add-on option for suggestions for improving patient safety culture in hospitals was given in the questionnaire and the most common or repeated responses were considered as key suggestions. They include:

- Proper monitoring of patients and ensuring good behaviour
- Implementing a patient-first approach
- Improving patient communication skills
- Pro-active and fast decisions
- Assessment of the hospital's patient safety culture

Conclusion

Based on the study, although the overall awareness about patient safety among urban Indian patients is high, there is a general lack of awareness about ways of dealing with patient safety issues. Given the high level of interest in participating in patient safety programs, such programs should routinely include patients for optimising the chances for safer provision of healthcare.

AFTERWORD

Pyush Misra
Trustee,
Consumer Online Foundation

Prioritise Patient Safety to Achieve Universal Health Coverage

"Healthcare should not only be of top quality, but also safe for the people receiving it. In fact, universal health coverage itself is not just about accessibility and affordability, but quality and safety as well. So much so that, patient safety is considered a fundamental component of both quality health services and achieving universal health coverage! But, when will we be able to really ensure that no one is harmed in healthcare?"

– Pyush Misra

Quality healthcare is defined by patient safety. The Institute of Medicine (IOM) considers patient safety 'indistinguishable from the delivery of quality healthcare'!

WHAT CAN BE more ironic than facing a health risk by going to a hospital? Indeed, while the intention is to get better, many people often end up getting worse!

Most of us have heard horror stories of new medical complications unexpectedly arising because of the treatment itself.

Visualise this – a road accident victim is rushed to a hospital and undergoes a minor surgery. However, he ends up paralysed as the staff bungled up with the anaesthesia.

An old man who is admitted for dengue fever slips and falls on his way to the bathroom, requiring a joint replacement surgery. He faces severe bleeding due to high dosage of medication during the surgery and collapses on the operation table itself.

A child who is hospitalised for observation following a fainting spell, develops pneumonia and takes months to recover from what should have been a regular hospital visit!

A nurse mistakenly inserts a feeding tube into the lung of a girl rather than her stomach. Her lungs are filled with fluid and the error is not discovered until a day later. However, her body is irrevocably damaged and she dies a few days later.

A woman keeps complaining of body pain and exhaustion which is dismissed by the physician as the diagnostic reports fail to detect the cancerous growths in her stomach until it is too late.

These are but a few instances of the hospital mishaps that play havoc with a patient's health and life itself. Alas, patients are often given the wrong drugs, the wrong dosage or a combination of drugs that interact poorly with their body. New infections can be acquired in the healthcare setting due to lack of cleanliness, ventilation, air conditioning or even personal protective equipment. Bleeding and blood clots often occur as a result of negligent care following a surgery. A diagnosis may be wrong, misread or delayed, thus interfering with the treatment. Then there are unsafe injection and transfusion practices, procedural errors, radiation errors, equipment failure and even patient identity errors. Not to mention the issues that crop up due to improper care transition and discharge errors. Overworked healthcare professionals or understaffed facilities are also a breeding ground for trouble.

Any of the above slipups – whether due to neglect or other inadvertent conditions – can lead to dangerous complications like infections, slow recovery, additional treatments, higher medical costs, readmission and even unnecessary death. The harm can be physical, mental or even emotional.

Such scenarios become a hotbed for medical malpractice cases!

Making Patient Safety a Responsibility

The World Health Organisation (WHO) defines patient safety as "the absence of preventable harm to a patient during the process of healthcare and reduction of risk of unnecessary harm associated with healthcare to an acceptable minimum".

Both the quality and quantity of healthcare services has enhanced manifold. However, another fact is that the very complexity of modern healthcare systems has also multiplied the possibility of harm to the patients. In fact, patient safety has become a global public health issue!

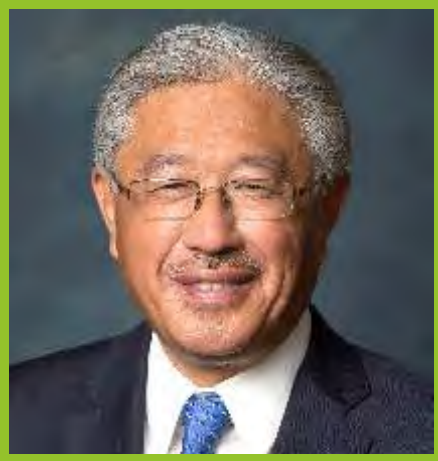
The occurrence of adverse events due to unsafe care is likely 1 of the 10 leading causes of death and disability in the world! – WHO estimates

Unsafe care undermines every goal of healthcare. The cause could be human, system failure, medical complexity or something else. But it is the patient who ends up paying the price, in more ways than one.

What we need is a systems approach and local solutions to improve patient safety. The focus has to be not just on preventing errors, but also learning from the errors that do occur. In fact, continuous improvement based on learning from errors and adverse events is a cornerstone of ensuring patient safety. This emphasis on safety should be extended into formal education as well to increase patient safety learning and develop solutions.

The scenario right now is of a blame culture, where everyone looks for someone to blame when a mistake or adverse event happens. We have to shift to a safety culture that seeks to understand the root cause of the incident rather than just who was involved.

"For a sustainable UHC, evidence-based patient safety systems and practices have to be established in all countries as one of the critical healthcare standards."



– Victor J Dzau,
MD President, National Academy of Medicine
(Third Global Ministerial Summit on Patient Safety, April 2018)

The answer lies in implementing protocols and other strategies to mitigate errors and keep patient health risks as low as possible. The answer lies in getting accredited as it will strengthen the overall healthcare system, thus reducing preventable harm to the patients during treatment.

Patient safety should be a top concern not just for the medical personnel, but every single department in a healthcare facility - from the emergency room to housekeeping to the cafeteria too!

Universal Health Coverage

Patient safety is an integral component for improving quality of healthcare, which is imperative for achieving the goal of universal health coverage (UHC) as envisaged in both our National Health Policy 2017 and the UN Sustainable Development Goals.

The efforts for safe healthcare will definitely yield higher standards of clinical care. It will slowly create an environment where better overall care is possible. Moreover, investments in reducing patient harm can lead to significant financial savings, and more importantly, better patient outcomes.

Conclusion

Despite global efforts, patient safety is not getting the necessary importance as yet. As a Lancet study quotes, "Efforts to advance UHC are mainly focused on improving access to services and the financing structures behind them. Quality and patient safety are largely neglected, especially in low-income and middle-income countries."

When will we understand that it is patient safety that will break one of the access barriers and encourage people for early access to healthcare? And this will, in turn, accelerate progress towards universal health coverage!

Bina Jain
• Former President, All India Women's Conference (AIWC)
• Chairperson, Healthy You Foundation, New Delhi

Overcoming Medication Errors to Drive Safety for Patients

"Each one of us has to take medicines at some point or the other to prevent or treat an illness or injury. However, the medication itself can cause serious harm if it is incorrectly prescribed, dispensed, administered, monitored or even stored! Avoiding unsafe medication practices and errors has emerged as a global challenge."

– Ms. Bina Jain

The most detrimental patient safety errors are related to the prescription and use of medicines!

MEDICATIONS ARE THE most common interventions in healthcare. Doctors prescribe pills for many a reason – from getting well to preventing illness to maintaining our health. The growth and improvement and healthcare services over the decades is hand-in-glove with a substantial increase in the use of medications.

However, medication-related harms constitute the greatest proportion of the total preventable harm due to unsafe care! It has been estimated that the world loses an estimated US$ 42 billion annually on medication errors alone. This excludes lost wages, productivity and healthcare costs. Not to mention the incidental pain and suffering that remains incalculable.

It is projected that 5% of all patients who are admitted to a hospital experience a medication error while 1 out of every 4 patients can get affected by life-threatening ailments.

An average hospital will have one medication error every 23 hours or every 20 admissions.

The highest rate of medication harm occurs in elderly patients followed by intensive care unit and emergency medicine.

The undesirable outcomes of medication errors range from adverse drug reactions, drug-drug interactions and lack of efficacy of the treatment/medication to poor patient experience, increased use of health services and medication-related hospital admissions. The fallout can affect the quality of life of the patient, ranging from severe physical harm, disability or emotional damage (like loss of a limb, poor memory or depression) to even death.

The United States National Coordinating Council for Medication Error Reporting and Prevention defines a medication error as "any preventable event that may cause or lead to inappropriate medication use or patient harm while the medication is in the control of the healthcare professional, patient or consumer. Such events may be related to professional practice, healthcare products, procedures and systems, including prescribing, order communication, product labelling, packaging and nomenclature, compounding, dispensing, distribution, administration, education, monitoring and use".

Indeed, medication errors is a broad arena and can take place at different levels of the healthcare process - prescribing, transcribing, dispensing, administration or monitoring. The errors can be by omission or commission – it can even be a slip or a lapse.

Healthcare professional – A doctor prescribes medications to help a patient recover and attain good health. But what if the physician fails to properly diagnose the patient's condition or understand their medical history before prescribing a treatment? For instance, a medicine can have unintentional side effects if the patient has hypertension or is even allergic to certain substances. Or it may create an adverse reaction if the patient is taking other medications for diabetes or even health supplements. The error could be ineffective prescribing, underprescribing or overprescribing.

Here, it is not just about the wrong medication, at times, even the dose, frequency or administration route may be incorrect. The physician has to specify the dosage (often based on the patient's height, weight and other characteristics), when it has to be taken and for how long.

However, can the healthcare professionals be blamed every time? There are countless number of prescription and over-the-counter drugs in the market. Many of them have confusing names, alternative uses and so on. This is compounded by limitless health supplements, herbs, potions and lotions that people often use as self-treatment. To add to this, new medications are introduced almost every day. It is difficult to understand and keep track of all of them, let alone decipher the risk of complications due to interactions between substances, the most common being liver or renal failure.

Can we overlook the fact that the physicians are often distracted, overworked or fatigued? They have a number of duties and time pressures in the hospital that can cause a lapse of judgment when interacting with a patient or writing a prescription. Not to mention the lack of sufficient resources and support at times. They are often called to prescribe for increasingly complex medical needs, where they may lack experience or drug knowledge.

At times, the problem may spring from illegible handwriting, misunderstood symbols, use of abbreviations or even confusion over similarly named drugs.

Examples of prescribing faults and prescription errors

Type of error	Example	Ourcome
Knowledgle based	Being unaware of the interaction between warfarin and erythromycin	Warfarin toxicity
Rule based	Prescribing oral treatment in a patient with dysphagia	Lung aspira-tion or failure to treat
Action based	Being distracted, writing diazepam for diltiazem	Sedation
Technical	Writing illegibly, so that 'Panadol' (paracetamol) is dispensed instead of 'Priadel' (lithium)	Loss of effect
Memory based	Forgetting to specify a maximum daily dose for an 'as required' drug	Poisoning or unnecessary treatment

Transcription – It has been noted that computerisation of health records and electronic prescribing has reduced the scope of medication errors. However, an error can arise when a personnel is entering the medication information into a computer system. Something as simple as wrong drug selection from a drop-down menu can lead to grave consequences.

Overmedication, or even wrong medication, can lead to antibiotic resistance!

Pharmacy – The prescription is filled by the pharmacist, but what if he/she makes a mistake - like dispensing an incorrect drug, dose, quantity or strength. This could be due to a mechanical lapse or can be attributed to confusion over similar naming, labelling, packaging, etc. Illegible handwriting of the physician can also cause a mix-up. Or, the drug may have deteriorated due to poor storage practices.

It is not just about poor drug distribution practices here. The pharmacist may fail to detect drug interactions, not counsel the patient appropriately or give improper directions.

Medication safety was also the theme for World Patient Safety Day 2022.

The campaign called on stakeholders (clinicians, patients and decisionmakers) to prioritise and take early action in key areas associated with significant patient harm due to unsafe medication practices.

The Global Patient Safety Challenge has developed a strategic framework that identifies the four domains of the Challenge as:

- Patients and the public
- Healthcare professionals
- Medicines
- Systems and practices of medication

The framework describes each domain through four sub-domains. The three key action areas - high-risk situations, polypharmacy (concurrent use of multiple medications) and transitions of care - impact each domain. It emphasises the need to adopt a systems approach and promote safe medication practices to prevent medication errors and reduce medication-related harm.

The healthcare provider who actively made the medication error usually becomes the 'fall guy' – he/she may be punished by the hospital or even be sued by the patient for medical malpractice. However, the WHO upholds that the latent factors in the system that led to the occurrence of the error should be identified and corrected.

Administration – A prescription passes through different levels of care starting with the doctor, then to the pharmacy and finally to the nurse who administers the medication to the patient. The medication error can take place earlier or even at the point of delivery.

The nurse may fail to read the prescription properly and miss a drug, administer the wrong drug or give a lower/higher dose. There can be cases of giving an extra dose, incorrect strength/rate or choosing an incorrect route of administration. And what if the medication is given for a longer or shorter period of time than prescribed? Any error in the timing of the dose – like with, before or after food – can also interfere with its effects, leading to under or overdosing.

WHO Global Patient Safety Challenge

Multiple interventions have been developed to address the frequency and impact of medication errors, yet their implementation remains sporadic. Acknowledging this substantial burden and recognising the complexity of medication-related harm prevention and reduction, the World Health Organisation (WHO) identified 'Medication Without Harm' as a Global Patient Safety Challenge.

What Can Be Done Here?

The error can be human or due to flaws in the system; but understanding the magnitude and nature of harm remains crucial. Especially so as a majority of the adverse drug events go unreported for one reason or the other!

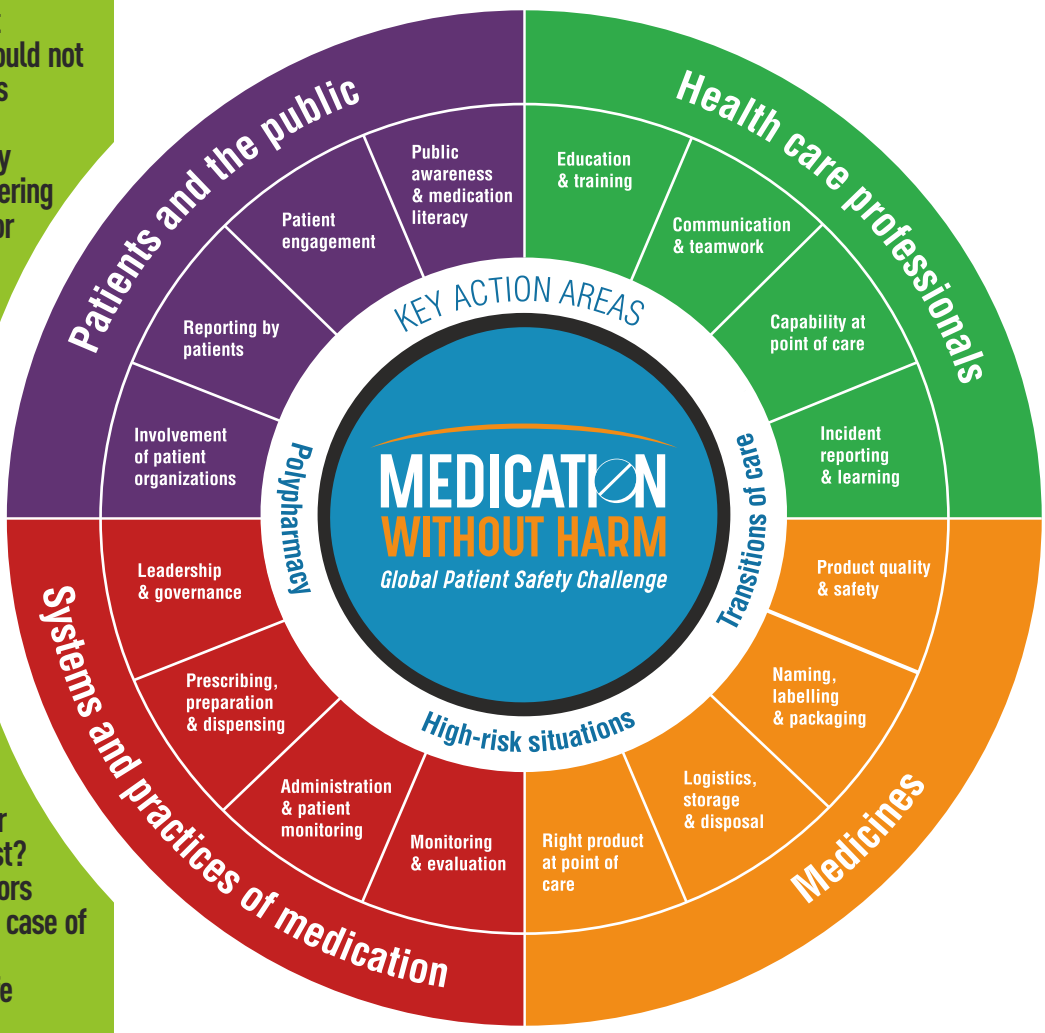
What we need is standardised protocols and procedures that will serve as a backup to detect mistakes. When safeguarding processes are in place at different levels of healthcare, medication errors can be quickly identified and corrected. This can be in the form of:

- Standard procedures for storage of medications that look alike or sound alike
- Proper communication between the different providers
- Verification practices before medication administration
- Involvement of patients in their own care

Most hospitals have developed their own strategies to prevent medication errors – like spelling out the drug name, dosage, frequency and route of administration without any abbreviations, doublechecking the dosing and

Another case in point is that healthcare professionals should not prescribe strong medications without conducting proper diagnostic testing. One of my relatives complained of shivering in an arm and leg. The doctor suspected Parkinson's disease and asked to take medicines for 10 days before conducting tests. The old lady started shivering uncontrollably and her body turned cold after taking the first medicine itself. I happened to reach there at the right time and it took great efforts to bring her situation under control.

Why didn't the doctor issue due warning, precautionary instructions or prescribe an antidote at least? All of us know that the doctors are not directly reachable in case of an emergency. What if the consequences had turned life threatening?



frequency of all high-alert medications, rechecking the calculation to ensure that the patient gets the right therapeutic dose, etc.

Why can't we make it mandatory for doctors and hospitals to provide computerised prescriptions to ensure clarity as mix-up of even a single letter in the name of a medicine or confusion in the spelling can lead to disastrous consequences?

In general, it is the duty of every healthcare personnel to approach every prescription with caution. Physicians who write drug orders and prescriptions should mention the patient's age and weight on the prescription along with the diagnosis based on which the treatment has been prescribed. It should be a common practice to provide clear instructions on doses, number of pills and how and when the medication is to be taken. These will allow both the pharmacist and the nurse to crosscheck before dispensing and administering the medication respectively. It opens the communication channels even as it reinforces the treatment plan and provides ample opportunities for patient education.

Pharmacists, on their end, can provide supplemental directions to the patients seeking the medication – like taking it with food, avoiding alcohol or even avoiding sun exposure, as needed.

Above all, the culture of blame has to be eliminated. Medication errors are a systemic problem that call for an open and clear reporting system sans any repercussions. It is only when every error is reported – including near misses – that healthcare providers can learn from the mistakes and keep them from recurring. Only then will the environment promote patient safety!

Conclusion

Apart from the obvious fallouts, medication errors also lead to decreased patient satisfaction and a growing lack of trust in the healthcare system. Preventing the avoidable harm and other damages due to medication errors remains a significant challenge in healthcare around the world.

Payal Agarwal
Editorial Consultant

The Looming Threat of Errors in Diagnosis

"Timely and accurate diagnosis is the cornerstone of efficient and effective healthcare. It is based on the diagnosis that appropriate treatment can be initiated to heal the patient and achieve optimal outcomes. Any breakdown in the diagnosis can have serious repercussions for the patients"

– Payal Agarwal

Doctors are expected to know everything about a disease or sickness. But they too can make mistakes in the diagnosis!

WHEN WE ARE sick or injured, we rely on healthcare professionals to find out what is wrong with us. This diagnosis is the crucial first step as it determines the course of treatment and defines our path to recovery and well-being.

But what if something goes wrong at the diagnostic stage itself? A recent study concluded that most of us will experience at least one diagnostic error in our lifetime! Diagnostic errors can crop up both in the outpatient and hospital settings.

Indeed, diagnostic errors are more common than we think. These kind of errors breakdown the healthcare process and can lead to harm to the patients.

Diagnosing the Diagnostic Errors

The U.S. National Academy of Sciences, Engineering, and Medicine (NASEM) defined diagnostic errors as 'the failure to establish an accurate and timely explanation of the patient's health problem or communicate that explanation to the patient'. The error can be in the form of:

- **Delayed diagnosis –** This is an unintentional delay in the diagnosis. It should have been made earlier, but maybe correct or sufficient information was not available at that time. in fact, it often happens that many illnesses are not identified until the symptoms persist or worsen. Delayed diagnosis of cancer happens to be the leading entity in this category.

- **Wrong diagnosis –** A health issue can be mistaken for something else, primarily due to similarity of symptoms. For instance, a heart attack is wrongly diagnosed as a case of acid indigestion! The mistake comes to light only when the true cause is diagnosed at a later stage.

- **Missed diagnosis –** The diagnosis is not made at all and the patient's medical complaints are left unexplained. Undiagnosed chronic fatigue and chronic pain are the most common in the category.

The causes of diagnostic errors can be varied. While healthcare professionals are well-trained to make a medical diagnosis, they may not be familiar with every symptom or a health condition may be outside the scope of their speciality. This often happens in the case of rare diseases.

Also, when a patient has multiple conditions, they can mask certain symptoms or lead to an incomplete diagnosis. At times, failure to refer a patient to the right specialist can also cause gaps in the diagnostic process.

Not to mention, a patient may overlook to disclose small details of their medical history which can interfere with the diagnosis and lead to inaccurate conclusions. Open and honest communication with the healthcare professional is crucial here and the latter should also have access to the patient's entire medical history.

On the other hand, it is noticed that healthcare professionals are often in a hurry and do not spend enough time with the patient or do not listen to their complaints properly. Unprofessional clinician behaviour is often noticed - like ignoring patients' knowledge, disrespecting patients, operating from a biased approach or forming conclusions without listening properly to the patient, ignoring changes in symptoms, overconfidence, etc.

Diagnostic Testing

The errors can originate from the laboratory testing space as well. It is estimated that more than 70% of clinical decisions are based on information derived from laboratory test results. But, what if the healthcare professional does not order the necessary medical tests or fails to read the laboratory reports properly?

The error could also emanate at the laboratory end. Like, the test being conducted erroneously, problems with the testing apparatus or incorrect conclusions by the testing professionals. Then there could be delays in generating the results or in communicating them to the healthcare team.

> Laboratory professionals must assist clinicians in selecting the right test for the right patient and provide the right report at the right time to facilitate diagnosis and treatment.
>
> ***– Dr Aarti Khanna Nagpal,***
> *Senior Consultant &*
> *Head-Hematology and Biochemistry,*
> *PathKind Reference Laboratory*

A laboratory error is defined as any defect that occurs during the entire testing process, from ordering tests to reporting results, that in any way influences the quality of healthcare.

Diagnostic errors lead to negative health outcomes, increased healthcare costs and decreased patient satisfaction. the consequences can be devastating and possibly even fatal.

Reducing the Incidence

Doctors need to spend more time with the patients and be attentive while at it. Discuss all the symptoms and get a complete picture of the medical history at all times. Physically examine the patient, order diagnostic tests as needed and review the results with a careful eye. Synthesising the available evidence and information remains crucial for making the correct diagnosis.

It is often noted that healthcare professionals fail to communicate the diagnosis with the patients or their

There is a huge regulatory vacuum in the clinical diagnostic testing space. The labs function under market-led and self-imposed norms leading to non-standardisation of quality.

The Government of India did set up a legal framework for regulation of private labs by enacting the Clinical Establishments Act, 2010 that prescribes the minimum standards for registration. It has been over 13 years now – while 18 states and union territories have notified the Act, none of them have actually brought in rules and mechanism to implement it.

In July this year, the state of Telangana informed the High Court that it started regulating and monitoring clinical establishments under the Act over a year ago. It claims to be the first state to implement the legislation – clinics, hospitals, labs, etc. that are not registered with the State Health Department will be punished with hefty fines, suspension or cancellation of the license. However, in reality, no action is being taken against the errant private healthcare facilities!

families or do it in an ineffective manner. They could be being unresponsive to questions or failing to follow-up after the diagnosis. Here, there is also a need to engage the patients and understand their experiences based on their complaints and feedback.

This calls for a patient-centric model that fosters strong communication and engagement with the patients, being responsive to their needs and preferences, thus laying the building blocks for a trusting and healing relationship!

We need a combination of interventions like improving the knowledge and skills of the healthcare providers to enhance their clinical reasoning abilities as well as addressing systems issues, such as test ordering processes, communication, recordkeeping, etc.

Medical laboratories should implement effective quality improvement plans to identify and prevent errors to ensure the reliability of the test results. This calls for both continuous education of laboratory personnel and adopting newer technologies.

Accreditation can play a crucial role in mitigating the risks with constant surveillance to ensure that everything works accurately and precisely. After all, placing them in an error-proof environment where the systems, tasks and processes are well designed will safeguard them from making mistakes.

Conclusion

Clinical champions are those who learn from the errors while keeping a sharp lookout for potential triggers of errors.

Common Types of Diagnostic Errors

Delayed Diagnosis

Failure to Diagnose an Unrelated Disease

Failure to Diagnose Related Disease

Missed Diagnosis

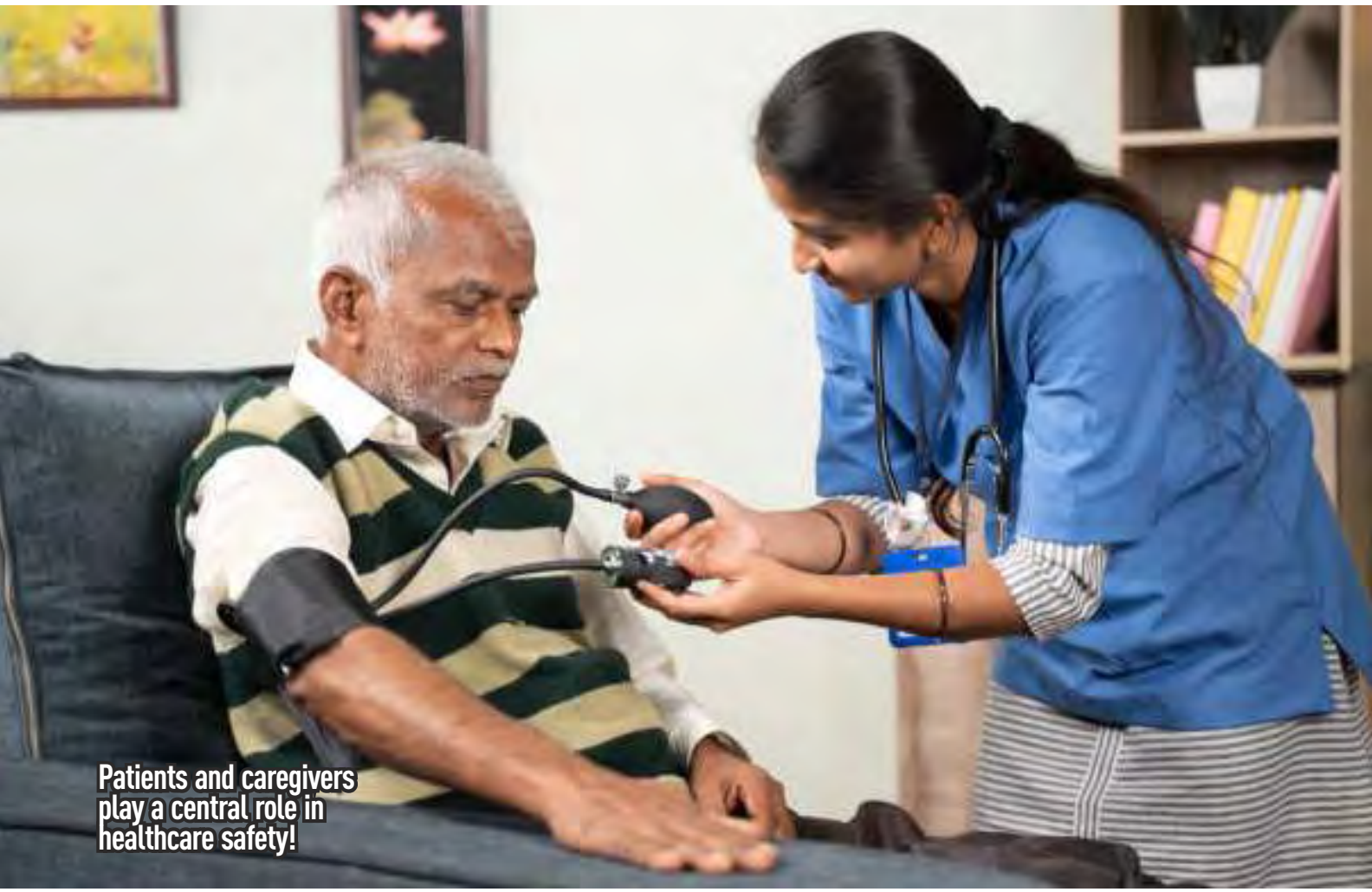
Failure to Recognize Complications

Misdiagnosis

Wajahat Habibullah, IAS (Retd.)
Former Secy. to the Govt. of India
Chairman - PSAIIF, New Delhi

Patient Engagement: Fostering a Partnership Culture for Safe Healthcare

It is now well-recognised that patients themselves play a significant role in minimising the avoidable harms during healthcare. It is the duty of the authorities and healthcare providers to facilitate their engagement at all levels of interaction!



Patients and caregivers play a central role in healthcare safety!

AS THE WORLD moves towards recognising the need and importance of patient safety in healthcare, the focus is expanding from simply healthcare institutions and professionals alone to the critical but unpredictable aspects of human behaviour. Vital to strategies and solutions to improve patient safety must be the patients themselves, caregivers and the families as well.

In 2004, the World Health Organization (WHO) identified patients, families and community engagement as one of the six initial patient safety priorities, and it continues to be a core priority of WHO patient safety initiatives.

"Evidence shows that when patients are treated as partners in their care, significant gains are made in safety, patient satisfaction and health outcomes. By becoming active members of the healthcare team, patients can contribute to the safety of their care and that of the healthcare system as a whole." - WHO

Patient and family engagement are imbued in the World Health Assembly Resolution WHA72.6 – 'Global Action on Patient Safety' urging Members States 'to put into place systems to support the active engagement, participation and empowerment of patients, families and communities in the delivery of safer healthcare'.

Hence, recalibrating the paradigm from care designed 'for patients' to care designed 'with patients', patient and family engagement has been included as one of the seven strategic objectives of the Global Patient Safety Action Plan 2021–2030. It states, "Patient engagement and empowerment is perhaps the most powerful tool to improve patient safety. Patients, families and other informal caregivers bring insights from their experiences of care that cannot be substituted or replicated by clinicians, managers or researchers. This is especially so for those who have suffered harm. Patients, families and caregivers can serve as vigilant observers of a patient's condition and can alert healthcare professionals when new needs arise. Given proper information, then, the patient and family can help to be sensors of the system."

It then only follows that the theme for this year's World Patient Safety Day itself is 'Engaging Patients for Patient Safety'. With the slogan 'Elevate the Voice of Patients!' WHO calls on all stakeholders to take necessary action to ensure that patients are:

- involved in policy formulation
- represented in governance structures
- engaged in co-designing safety strategies and
- become active partners in their own care

This can only be achieved by providing platforms and opportunities for patients, families and communities to raise voice, concern, expectations and preferences to advance safety, patient centred care, trustworthiness and equity.

The WHO established the 'Patients for Patient Safety' programme to foster involvement of patients and families in the governance, policy, health system improvement and their own care.

Giving Patients a Voice in their Healthcare

Patients have more information on their own health that just about anyone else in the healthcare system. Family members and caregivers are well-placed to sense events leading to preventable harm, which might otherwise go unrecognised. Therefore, healthcare providers must work in partnership with them to both avoid compromising safe care and to improve health outcomes. The Joint Commission International (JCI) also mandated that healthcare organisations should 'encourage patients' active involvement in their own care as a patient safety strategy'.

Patient centred care is "providing care that is respectful of and responsive to individual patient preferences, needs and values and ensuring that (these) values guide all clinical decisions" – 'Crossing the Quality Chasm' report by the Institute of Medicine in 2001

The onus falls on the healthcare professionals to play a proactive role in empowering the patients and their families to make essential contributions that will prevent errors and avoid adverse occurrences, thus making healthcare safer and a more wholesome experience and outcomes for the patients.

However, this calls for a massive shift in provider attitude and behaviour which could be challenging and uncomfortable initially. Healthcare providers have to relax some measure of control, accepting the role of increased patient participation and overcome their own inherent reluctance towards involving the patients. The patients themselves may be unwilling to get involved or may not even be aware that they can have a say in their treatment. Other cultural barriers will crop up from time to time.

High-level commitment, backed by system-level efforts and organisational support with a top-down approach is essential for integrating patient and family engagement into the healthcare system. The procedures, policies and

We need a dramatic shift in institutional culture that has historically limited patient engagement!

structures also have to be evolved to include patient participation and empower them to ensure safe care.

Efforts should focus on increasing the awareness and participation of patients to have them proactively involved in achieving a culture of safety. For this patient, caregivers and families should be encouraged to:

- Ask questions when a symptom or treatment has been inadequately explained
- Monitor the self-administration of medications
- Alert care teams when something does not seem right
- Detect and report adverse events
- Notice safety concerns or factors overlooked during care provision
- Identify disruptions during care transitions
- Understand error-prevention strategies
- Participate actively in decisions about their care
- Participate in hospital safety initiatives or advisory councils

By this means patients can become a second layer of defence against medical errors and can preclude potential mistakes from their providers. On their part, the healthcare professionals should:

- Actively listen to what the patients say and give additional time to understand their perspective
- Educate patients on their condition, treatment options and self-care
- Provide individualised counselling or teaching
- Provide patient educational materials
- Use posters and brochures to encourage patients to speak up for their safety
- Focus on building trust and incorporating different perspectives

This will not only prevent patient safety errors, but also keep the patients from inadvertently precipitating errors – like missing a check-up or follow-up appointment, forgetting to take a medicine, stopping medication on their own and other unsafe behaviour intended or not, that can compromise their safety.

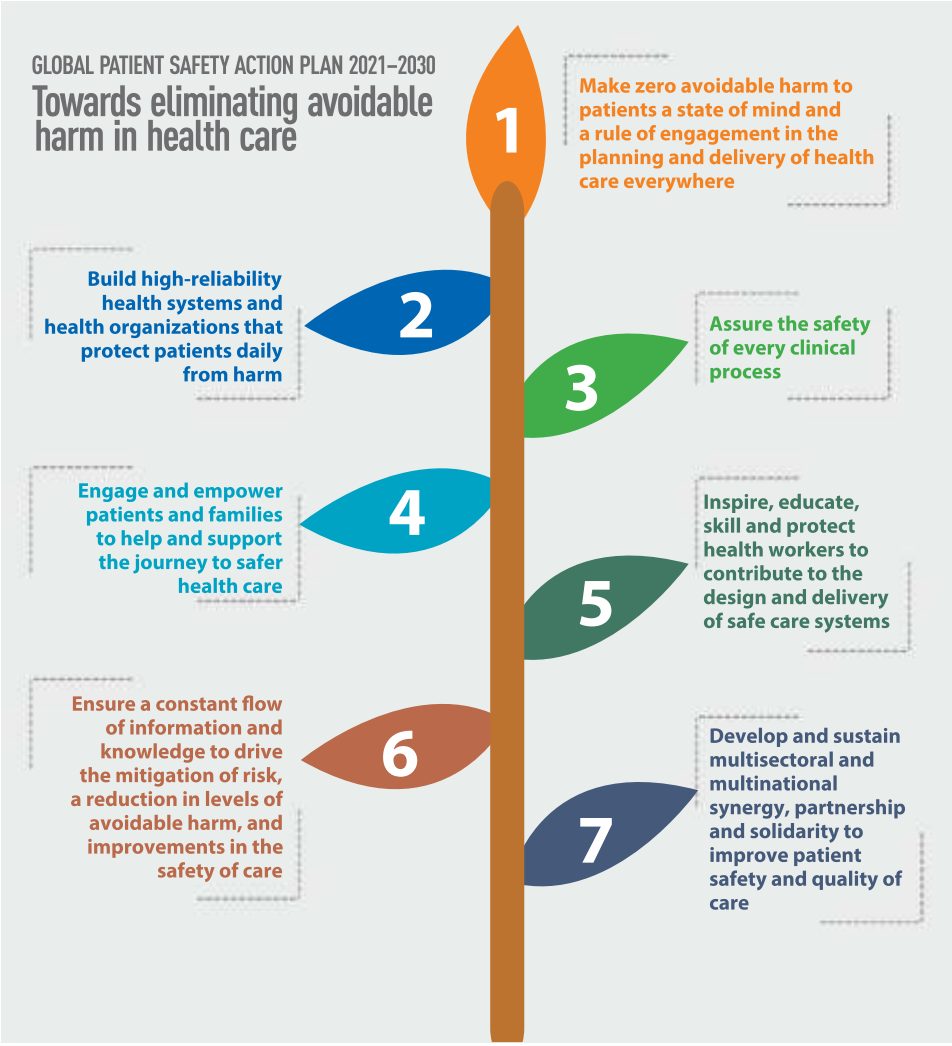
When systems open themselves up to patients rather than being reactive, it will improve both system efficiency and quality of care. Not only will there be reduced harm, greater levels of safety and better health outcomes but fewer complaints and improved satisfaction as well!

Regular patient surveys – especially hospitalised patients – about their satisfaction with the care received and potential of adverse events can become an effective and consistent error-detection mechanism. The emphasis should be on transparency in reporting errors and care problems.

Clear Communication

Communication plays a critical role in the safe delivery of healthcare. The Joint Commission International (JCI) reported poor communication as a contributing factor in more than 70% of all hospital adverse occurrences that they reviewed.

The failure is not restricted to communication touch points among physicians and staff but also between the



A patient is under continual observation in a hospital setting. It is post-discharge that the healthcare team should ensure clear communication with patients, families and caregivers to promote safety through partnership. The focus should be on accurately communicating the patient data and ensuring complete understanding by the recipient.

healthcare providers and patients/family/caregivers. Incomplete, ineffective, inaccurate or missed communication can easily escalate into a patient safety threat and lead to preventable harm. Moreover, effective communication with patients becomes paramount for achieving shared decision-making and patient-centred care.

The ideal communication is clear, complete and effective across in all patient interactions – be it diagnosis, treatment or transition to other settings of care.

For this, doctors, nurses and other staff have to be willing to provide detailed explanations and encourage questions from patients. When a patient knows and understands what will happen during a surgery, he/she is unlikely to feel acute anxiety. Healthcare providers should understand that patients are suffering not just physically during an illness or accident, but also undergoing psychological trauma in consequence. An open and communicative bedside manner can ease apprehensions.

At present, in most situations, healthcare professionals merely diagnose the patient's condition and prescribe medications, diagnostic tests or other treatment without any explanation of the health problem. Even during discharge from the hospital, many patients are either not informed (or do not understand) what to expect or even what to do should their condition worsen or fail to show improvement.

What, then of patients that are altogether unknowing of their need to take medicine or unsure of how many times or how long medicine should be continued?

Break in communication is what sets the stage for adversity and harmful consequences. Here, it might also be highlighted that the complexity of discharge information needs to be simplified – if the patient is unable to understand the process clearly, it will lead to miscommunication.

Clear communication strategies and routine education of patients are crucial, especially relating to the medication regimens and follow-up. This should also ensure understanding of indication for therapy, intended outcomes and signs and symptoms of adverse reaction.

On balance, awareness of patient engagement is undoubtedly increasing among the healthcare fraternity. Nevertheless, much still remains to be done in making remedial action fully effective.

Conclusion

Several studies have revealed that employing patient and family engagement strategies reduces hospital-acquired infections, medical error and serious safety accidents as well as increasing patient satisfaction. A patient-centred care paradigm rests on building a safety culture that effectively places the patient at the centre of care with systematic interventions to pivot the role of patients at the heart of patient safety processes.

Dr. Anamika Wadhera
Director
Consumer Online Foundation

Pioneering Initiatives for Patient Well-Being

"There is no dearth of patient safety initiatives in our country. However, the efforts have to be synchronised and implemented in a comprehensive manner to even get a fair shot at achieving the national patient safety goals!"

– Dr. Anamika Wadhera

Integrated and sustained efforts are what will improve health outcomes in India!

PATIENT SAFETY IS a public health issue. There are varied challenges in the patient safety domain – from unsafe injections, medication issues and healthcare associated infections to medical device safety, anti-microbial resistance and biological waste management.

Over the past years, it is evident that India is taking cognizance of the evidence on patient harms and the effectiveness of interventions to improve patient safety. Multiple stakeholders in the public and private domains have implemented a wide range of initiatives for patient safety at different levels of care in both public and private sectors. There is a multiplicity of national and international stakeholders working in this area as well.

The Ministry of Health and Family Welfare (MoHFW), Government of India itself has undertaken various strategies and programmes both under the ambit of the National Health Mission and prior to it as well. Some of the primary ones are:

- Kayakalp Awards for cleaner healthcare facilities in government sector (2015)
- Mera Aspataal (My Hospital) for patient feedback on quality of health services (2016)
- Formation of National Technical Expert Group (N-TEG) on injection safety in India (2016, reconstituted in 2019)
- LaQshya for improving quality of labour rooms (2017)
- National Action Plan for Antimicrobial Resistance to combat resistance to antibiotics (2017-2021)
- Pharmacovigilance Programme of India (PvPI) to monitor the safe and effective use of medicines and reduce the risks (2010)

- Adverse Event Following Immunization (AEFI) to prevent untoward medical occurrences following immunization (1988)

In addition to the above, the National Quality Assurance Standards (NQAS) provide a framework through which hospitals can deliver quality and safer patient care services. It assesses hospitals from a patient, caregiver and staff safety perspective; builds staff capacity in adhering with clinical and evidence-based practices; ensures compliance to infection control practices; involves patients and relatives in decision-making for their treatment plan; and promotes a culture of patient engagement, learning, and continual improvement. Therefore, this reduces the 'knowing-doing' gap by translating evidence of effectiveness into routine practice.

The fifth edition of NABH Accreditation Standards for Hospitals (April 2020) replaced the chapter on Continuous Quality Improvement with a chapter on Patient Safety and Quality Improvement. This will increase the focus on patient safety in healthcare and ensure that national and international patient safety goals and solutions are being implemented in healthcare facilities. One important recommendation is to implement a robust incident reporting and learning system with well-defined sentinel events in every accredited hospital.

Accreditation of public and private healthcare facilities by NABH (under QCI) based on various accreditation standards is another ongoing initiative for standardisation of both quality and safety of healthcare. This is a robust system that involves regular assessment of the healthcare facilities to maintain the standards.

India was one of the foremost countries to sign the Global Patient Safety Action Plan 2021-30. In 2019, we were one of the four countries at the global level to join the WHO led Global Patient Safety Collaborative (GPSC). As part of this, India is receiving technical support to strengthen leadership, education and training capacity as well as research for accelerated improvements in patient safety.

Our editor and founder of Patient Safety and Access Initiative of India Foundation, Prof. Bejon Kumar Misra played a contributory role in drafting the NPSIF.

These policy initiatives need to be supplemented with interventions at the facility levels to truly make a difference!

"Patient safety is everyone's responsibility!"

– This opening statement of the NPSIF highlights the importance of every stakeholder's contribution to patient safety: central and state governments, patient and consumer rights groups, professional associations, medical education institutions, agencies for quality and accreditation, healthcare providers at public and private healthcare facilities of all sizes and functions, millions of patients and their families, and the surrounding community.

Health being a State subject, various patient safety and quality initiatives are undertaken at both state and district levels.

Many private and non-profit organisations are actively raising their voice about safety-related concerns in healthcare institutions while working to increase awareness about patient safety and best medical practices among patients and the general public. The focus is on reducing avoidable harm with the active involvement of the healthcare provider, the patient and the community at large. They also pioneer to foster a culture of patient safety while empowering patients and their families to engage in their own care.

Patient Safety Under a Single Umbrella

It is clear that patient safety is being implemented in a fragmented manner by multiple stakeholders, even with an overlap at times. Considering this, the MoHFW constituted a multi-stakeholder Patient Safety Expert Group in August 2016 to bring the patient safety initiatives under a comprehensive policy framework and operationalise a patient safety agenda at the national level. They were also tasked with developing a National Patient Safety Implementation Framework (NPSIF) that will ensure implementation of patient safety activities in a coordinated manner and contribute to the overall agenda of improvement of quality of care within the UHC context in India.

The NPSIF (2018-2025) is fully aligned with the 'Regional Strategy for Patient Safety in the WHO South-East Asia Region (2016-2025)' and endorsed by the 68th Regional Committee of WHO South-East Asia Region.

This seven year framework comprising of six objectives and a communication strategy (clearly

defined with 21 priorities and 81 interventions for effective implementation) is intended to serve as a comprehensive guideline and roadmap toward strengthening the safety of patients. The six strategic objectives are:

- To improve structural systems to support quality and efficiency of healthcare and place patient safety at the core at national, sub-national and healthcare facility levels
- To assess the nature and scale of adverse events in healthcare and establish a system of reporting and learning
- To ensure a competent and capable workforce that is aware and sensitive to patient safety
- To prevent and control healthcare associated infections
- To implement global patient safety campaigns and strengthen patient safety across all programmes
- To strengthen capacity for and promote patient safety research

It also enumerates concrete action plans to further strengthen each patient safety key priority area (detailed below) with detailed timelines for implementing the framework:

- Safe surgical care
- Safe injections
- Medication safety
- Safe childbirth
- Blood safety
- Medical device safety
- Safe organ, tissue and cell transplantation and donation

The NPSIF is an overarching national framework. States and union territories have the flexibility to design their own institutional mechanisms and modalities for quality and safety in the public and private sectors. They have been directed to constitute patient safety committees at state and district hospitals (subsuming existing committees on infection prevention and control and biomedical waste management). They should also develop a State Patient Safety Action Plan and include patient safety components in state Program Implementation Plans (PIP) under Quality Assurance. Mechanisms should also be developed to redress patient safety grievances and to report patient harm incidents under the National Health Mission.

The MoHFW organised a 2-day workshop on 16-17 February, 2023 (in collaboration with WHO Country Office for India) to bring key stakeholders on a common platform to sensitise them on their role in the implementation of NPSIF and strengthen their capacity on various facets of patient safety including the development of state action plans.

Speaking at the event, Dr Bharati Pravin Pawar, Minister of State, MoHFW said that "India has always recognised the importance of patient safety and prioritised it as a public health issue."

Dr. Roderico H Ofrin, WHO Representative to India, said, "The collective commitment and efforts of central and state governments with support from all stakeholders will create an environment in which no one is harmed in healthcare and every patient receives safe and respectful care, every time, everywhere."

Based on the NPSIF, the syllabus for undergraduate and postgraduate level medical, nursing and pharma courses is being revised to incorporate adequate learning objectives for patient safety based on the WHO Patient Safety Curriculum Guide.

Finally, the framework to integrate key patient safety initiatives across the country has also enhanced the reach and impact of these programs. Progress on the implementation is steady but still remains slow. It needs to be implemented at all levels and modalities of healthcare provision, including prevention, diagnosis, treatment and follow-up.

Conclusion

India is rapidly upgrading the healthcare facilities and improving the infrastructure to address the needs of our huge population. Patient safety has also evolved to a large extent. However, there is a pressing need to take many more concrete steps in this context.

Becoming an Active and Involved Patient

We, as patients have to rise to the occasion and be willing partners in our own healthcare!

Patients have to take ownership over their health and safety!

PATIENT SAFETY IS everyone's business – including you, the patient too! Indeed, the days when a quiet patient was considered a good patient are long gone as patients cannot and should not stay passive when they seek healthcare.

Consider this – Available evidence states that 15% of hospital expenditure can be attributed to addressing issues related to safety failures. These can be avoided if you are engaged in your safety, be it at the point of care, when things go wrong, in improving services, by advocating for change or holding the system to account!

The Inherent Barriers

Healthcare providers are encouraging and empowering patients to speak up during their healthcare. However, the fact remains that most people are hesitant and even feel apprehensive about being involved in their own care. Many of them blindly trust the doctors and nurses with the prevailing notion being that speaking up will be considered a sign of disrespect. They avoid asking questions as it can be akin to challenging or undermining the authority of the healthcare professionals. They are especially wary about raising concerns as it can appear confrontational.

Healthcare is increasingly delivered in the outpatient setting with shorter in-patient stays and more frequent care transitions. This increases the responsibility of patients, especially given the complex management of chronic diseases in the home and community.

How to Take Ownership?

Following are some ways in which you can and should check on different aspects of your healthcare when visiting a doctor or being admitted into a hospital:

- Provide a complete medical history. Share every single medicine that you are taking – be it prescription, over-the-counter, supplement or herbal potion – especially prior to a surgery. Inform about any allergies or other medical issues that can lead to a safety event. If in doubt, ask clearly if your medications can interfere with the treatment.
- When medicines are prescribed or a nurse is administering a medication, ask what is it and why you need it. Ask the purpose of the drug, the potential side effects, when and how to take it, directions for storage, etc. Find out about the risk of drug-drug or drug-food interactions.
- Read the prescription and understand the names and indications of the medications before leaving the clinic/hospital. Check the label every time you take any drug, note the expiry date and store them properly in their original containers.
- Ask about the need for a treatment or tests, when the results will come, the risk of complications and possibility of alternatives.
- Find out if you will be given antibiotics before or after a surgery to reduce the risk of infections. However, avoid taking antibiotics in regular situations, unless it is absolutely necessary, as they can cause side effects and increase antibiotic resistance.
- Inquire about the possibility of developing blood clots after a surgery and what is being done to prevent the same.
- Respectfully prompt the doctor or nurse to engage in safe behaviours by asking if they have washed their hands or sterilised an equipment prior to use.
- You can ask for aids to avoid fall injuries and other assistance that you deem necessary.
- Be on the lookout for possible lapses in the treatment, signs of infection and other complications. If you notice an error, defect or are simply concerned about a situation, talk to the nurse, physician or other authoritative person who is accessible.
- Use the healthcare organisation's reporting system – like hotline, suggestion box or feedback form – to voice concerns or report errors.
- Be actively engaged in the discharge planning and always attend the follow-up appointments without fail.
- Above all, always comply with the prescribed treatment, instructions or advice given to you whether in the hospital or at home.

"Questioning authority is never easy. But remember it's your body, your health, and your life. If you ever have questions or concerns about anything during your hospital stay, you have to speak up." - Nancy Foster, Vice President of Quality and Safety Policy, American Hospital Association

The Joint Commission International's 'Speak Up' initiative seeks to educate patients about safety hazards and provides specific questions that patients (and their caregivers) can ask to ensure safety.

"Every adverse event you report counts and can help redefine the safety profile of the drug. By doing so, you might be contributing to the risk management measures, due to which many patients would be saved without being denied the due benefit of the drug." - Dr. J Vijay Venkataraman, chair of IMA Headquarters Standing Committee for Pharmacovigilance

In sum, taking an active and informed role in your healthcare can prevent many errors. You can actually become the final check in the system!

It should be noted that PvPI also collaborates with NABH for pharmacovigilance skill development programs for healthcare professionals across India. Under the partnership, NABH-accredited hospitals can enroll as ADR monitoring centres with PvPI to ensure that the quality adverse event data is reported.

REPORTING MEDICATION ERRORS

Dr. Jai Prakash
Senior Principal Scientific Officer
& Officer-in-Charge,
National Coordination Centre-PvPI,
Indian Pharmacopoeia Commission

CONSUMERS CAN PLAY a vital role in improving patient safety by reporting adverse events or reactions directly to the appropriate authority. They are the main source of drug safety information as they can provide detailed information on the adverse event/adverse drug reaction experienced by them after taking any medication.

Pharmacovigilance Programme of India (PvPI) exists to monitor the safety of medicines and safeguard the health of over 1.4 billion people of India. The culture of reporting of ADRs has achieved remarkable success in the last one decade with expansion of PvPI. There are now 760 adverse drug monitoring centres (AMCs) under PvPI all over India, where healthcare professionals report the adverse events, however, reporting by the consumers/patients directly to the PvPI is relatively low.

Direct and spontaneous reporting of ADRs by patients or consumers offers various benefits in a pharmacovigilance system - like it is useful to find out new and unknown adverse drug reactions. As a consumer has detailed information about his/her disease, drugs used, relevant history (family, medical & drug history), allergic conditions, concomitant medications, adverse events, onset of events and many more relevant information, consumers can significantly contribute to provide new insights into safety of medicines.

Patient reporting adds new information, and perspective about ADRs in a way otherwise unavailable. As each patient is unique, the ADRs experienced by them may also be unique, so a patient can provide first-hand information on the way an AE/ADR affects their daily lives. Furthermore, the combined information about ADRs from healthcare professionals and patients could have a significant impact on signal detection of new, rare or serious ADRs which can lead to changes in labelling of drugs package inserts. This can contribute to better decision-making processes in pharmacovigilance. The present write-up attempts to sensitize the consumers/patients about reporting of AEs/ADRs to PvPI in a prompt manner.

The initiative of the PvPI to organise the National Pharmacovigilance Week from September 17th to September 23rd every year from 2021 onwards, and sensitise all stakeholders including consumers, has been a successful attempt in raising the awareness for reporting of ADRs by the consumers. The second National Pharmacovigilance Week had a consumer centric theme 'Pharmacovigilance: Encouraging Reporting of ADR by Patients'.The activities like Nukkad Natak, rallies, animation videos, posters were organised during the event.

Different Reporting Tools for Consumers

In India, to enhance consumer role in patient safety, Pharmacovigilance Programme of India (PvPI) has different reporting tools for Adverse Drug Reactions reporting for consumers.

1. Adverse Drug Reactions Reporting Forms

For consumers, PvPI has devised an ADR Reporting form (blue in colour) available on the website of Indian Pharmacopoeia Commission website (www.ipc.gov.in). Consumers can download the ADR Form and after filling they can directly send to PvPI or to a nearby ADR Monitoring Centre by post or email. Considering the kind of diversity in India, this form is available in 10 vernacular languages for the ease of reporting by consumers. The ADR reporting forms have been made in such a way that everyone can easily fill up the forms.

2. Mobile Application

For the ease of reporting ADRs by consumers and healthcare professionals, PvPI has launched a mobile application ADR-PvPI which can be used by anyone. Mobile app makes ADR reporting simple and effective for the betterment of patient safety.

3. Toll-free Helpline

PvPI has a toll-free helpline number - 1800-180-3024 - for the consumers to enable reporting of ADRs directly. This helpline number has been inserted into in-patient and out-patient departmental prescription slips/hospital cards at various hospitals across India. The toll-free helpline number is handled by qualified Pharmacovigilance officials. The Pharmacovigilance officials not only entertain ADRs being reported by the patients but also assist the patients regarding any medication and dosage regimen that is unknown or misleading. This tool for ADR reporting is one of the easiest ways to verbally communicate with the patients and ask for all the necessary details regarding the AEs and respond to their queries.

The adverse drug reaction reports coming from consumers through the mobile application and toll-free helpline have witnessed significant growth in recent times. This can be attributed to the effort put by PvPI and AMCs functioning under PvPI on training and sensitisation across the country. Further, PvPI sensitises the trainees from time to time about different topics like medication errors, antimicrobial resistance, polypharmacy, adverse drug reactions, etc. for onward dissemination of this information to their colleagues, friends, etc. including patients.

In conclusion, bringing patients directly into ADR reporting will not only increase the rate of reporting, but also improve signal detection. This societal move of involving patients/ consumers reporting will boost public confidence that they have a role to play in the field of patient safety!

"Patients must be the owners of their own data to be a safe patient. Being responsible patient is the most important criteria to be a safe patient in any health care system. Patients must take ownership of their own therapy and adherence along with their own data!"

Siva Prasada Reddy Maddirala Venkata,
Proprietor Pharmacist, Frederiksberg Pharmacy, Denmark

The International Alliance of Patients' Organizations (IAPO) is a unique global alliance representing patients of all nations across all disease areas and promoting patient-centred healthcare around the world. Formed in 1999, IAPO is a non-State Actor in official relations with the WHO. With 300 member organisations (including Patient Safety and Access Initiative of India Foundation) from 71 countries representing 50 disease areas, IAPO makes a stand for millions of patients from around the world.

IAPO has developed a Patient Safety Toolkit to help patients and patients' organisations to engage with stakeholders and contribute the patients' voice to actions that reduce harm and improve the quality and safety of their healthcare system. It even developed the IAPO Patients for Patient Safety (P4PS) Observatory - a single-point global platform for research of patients' expertise and experience to inform health policies. It has initiated a mapping exercise to gather the efforts of patient safety awareness raising globally, amplifying the patient voice in patient safety.

The International Pharmaceutical Federation (FIP) is the global body representing over 4 million pharmacists and pharmaceutical scientists. We work to meet the world's health care needs. FIP is a non-governmental organisation that has been in official relations with the World Health Organization since 1948.

OBITUARY

CEO of IAPO
Mr. KAWALDIP SEHMI
1960-2023

WE ARE DEEPLY saddened by the passing away of Mr. Kawaldip Sehmi, the esteemed CEO of International Alliance of Patients' Organizations (IAPO). He will always be remembered as the pillar and symbol of IAPO, bringing everyone together and ensuring that every patient's voice is heard. Being a cancer survivor himself, he was unwaveringly committed to advocating patient safety and passionately championed their rights globally. Fuelled by his personal experiences, his life work centred on promoting patient-centred healthcare. He was an active torchbearer for patient engagement in healthcare.

Mr. Kawaldip had extensive public health experience at the national, regional and international level. At IAPO, he triggered discussions on many forward-thinking topics, like meaningful patient partnerships to build back better health systems, regulatory affairs in Africa, and personalised cancer care in the Eastern Mediterranean Region. Appointed CEO in 2015, he was part of several boards, working groups and initiatives, and supported the development of multiple coalitions and partnerships to ensure that the patient perspective is heard. His relentless pursuit left an indelible mark on the fight against substandard and falsified medicines.

His qualifications included an MSc in the Public Health International Programme from the London School of Hygiene and Tropical Medicine, a Master's in Business Administration from the London Business School and Open University, and an LLB (Hons) from the London College of Law. Before joining IAPO, Mr. Kawaldip held the position of CEO at Richmond Psychosocial Foundation International and worked as Managing Director of Coram Children's Legal Centre. He was also the Director of the Global Health Inequalities Programme and Chairman of the European Network of Quitlines during the successful negotiations and ratification of the WHO Framework Convention on Tobacco Control.

All those who had the opportunity to interact with Mr. Kawaldip, will remember him as enthusiastic, full of life and coming up with brilliant ideas - one step ahead of anyone else. He was an avid learner, very knowledgeable about diverse topics, and always had a valuable thought to share in every discussion.

On behalf of The Aware Consumer editorial board and team members, we extend our deepest condolences to his family, friends and the global patient community. We will honour his memory by continuing to advocate patient-centred healthcare across the world!

FIP President
DOMINIQUE JORDAN
1960-2023

THE AWARE CONSUMER mourns with sadness the death of Dr. Dominique Jordan, President of the International Pharmaceutical Federation (FIP), following a period of ill health. Dominique was a Swiss community pharmacist. He became a member of FIP 20 years ago.

In 2018, Dominique was elected president of FIP. Before that, during 2014-18, he served FIP and global pharmacy as Chair of the Board of Pharmaceutical Practice. Dominique was an exceptional advocate for the Pharmacy profession and dedicated to advancing Pharmacy in every country. He was convinced that FIP was the platform by which this could be achieved.

During his FIP Presidency, Dominique led FIP through the global crisis of COVID-19 and introduced the vision of “One FIP”, which resulted in greater collaboration between the many constituencies within FIP and increased engagement with FIP Member Countries. In Dominique's home country, his actions to advance pharmacy included roles as President and CEO of Pharma Suisse, the Swiss association of pharmacists.

The Consumer Online Foundation (COF) and the Patient Safety and Access Initiative of India Foundation (PSAIIF) gratefully remembers the video address delivered by Dominique on World Quality Month during the first Global Quality Summit on Quality and Consumer on November 23, 2021, at Hyderabad, India.

The Pharmacy Profession is grateful for Dominique's dynamic and strong leadership, particularly during challenging times and especially during his months of ill health. The Aware Consumer extends deepest condolences and prayers to his loved ones.

UPDATE ...

Moving a Step Ahead

Update on the July edition

Our Efforts Sowing the Seeds for Change

It is with great pride and joy that we inform our readers that the July edition of our magazine is generating momentum at the national level.

Returning Unclaimed Money of Consumers

IT IS HEARTENING to witness a flurry of activity in the unclaimed money space. The Finance Minister made a series of announcements in the past couple of months that has spurred action on various fronts.

Many banks are constantly sending reminders to depositors to provide the nominee details for their bank accounts. The senior citizens are being asked to provide a proof of existence on an annual basis.

In mid-August, The RBI launched UDGAM (Unclaimed Deposits – Gateway to Access inforMation) - https://udgam.rbi.org.in/ - a centralised web portal to track unclaimed deposits across multiple banks. “The launch of the web portal will aid users to identify their unclaimed deposits/ accounts and enable them to either claim the deposit amount or make their deposit accounts operative at their respective banks”, the RBI statement read.

Seven banks – State Bank of India, Punjab National Bank, Central Bank of India, Dhanlaxmi Bank Ltd,South Indian Bank Ltd, DBS Bank India Ltd and Citibank have been onboarded as of now. The search feature for the remaining banks will be rolled out in a phased manner by 15th October, 2023.

Mr. Bhagwat Kisanrao Karad, Union Minister of State for Finance recently revealed in the Lok Sabha that Rs. 5,729 crore has been transferred from the RBI's DEA Fund to various banks over the past five years to reunite unclaimed deposits with their rightful owners.

In the insurance space, CAMSRep (a subsidiary of Computer Age Management Services repository) has built a contact tracing tool and is already working with a dozen insurers. It has resolved Rs. 100 crore worth of unclaimed benefits for about 40,000 policyholders in the last 12 months.

YOUR OPINION MATTERS

letters to the editor

We are truly humbled by the praise and acknowledgment that is flowing in from varied sources. Please feel free to send in your comments, views or feedback on The Aware Consumer magazine at bejonmisra@theawareconsumer.in – we will publish your opinions and implement your feedback while ensuring that your voice is heard on the right platforms.

(July issue: Where Does The Consumers' Hard-Earned Unclaimed Money Go?)

Many small deposits which have been lying in bank accounts that have not been operated for some time gets usurped by the bank with the excuse that minimum deposit requirements have not been met with. No such condition existed when the account was opened and nor were consumers cautioned about it.

Another phenomenon that I have seen is that in any account where there has been no debit transaction in a period of 6 months get blocked and preventing access to our own account until KYC is done all over again. This becomes a very difficult situation for someone who is overseas for some time and cannot access his account until he completes KYC after coming here. Doing KYC from abroad is a huge challenge. Banks cloak this with the excuse of security considerations.

The question is - can banks change terms and conditions after a depositor has entered into a contract?

– Rajesh Talati, Vadodara, Gujarat • rtalati@hotmail.com

I'm delighted to receive The Aware Consumer's July issue. View points of the Publisher & Editor, Prof. Bejon Mishra are worth preserving. For example, "Funds to the tune of Rs 70,000 to 85,000 crores lying unclaimed should be used for the consumer awareness, welfare and other related activities". It should be implemented by the Rulers at the earliest. Similarly, Editorial board member, Dr. Praful D. Sheth's remarks "Why there is no clear-cut policy on using the unclaimed money and other funds that rightfully belong to the consumer" will raise eye brows and certainly open the Pandora's box. In fact, this is the voice of consumers for decades together. Now, it is brought to the broad daylight.

RBI Governor's announcement regarding "Launching of common Portal to check unclaimed money with banks at one go" indicates some light at the end of the tunnel. It will be very helpful if it comes in force. Other articles on the subject/topic are really an eye opener for the consumers/general public.

– Dr N Murugesan, Former Director, Central Drugs Testing Laboratory, Chennai • drnmurugesan@gmail.com

My sister-in-law who is based in USA now, had randomly invested Rs. 20,000 in a pharma company around 14 years ago. After moving to USA, she completely forgot about it. On her last visit to India, she wanted to trace her SBI mutual fund investments and by chance, this forgotten investment came to light. To our untold surprise and happiness, those shares are worth a whopping Rs. 8 lakhs today!

However, despite making repeated visits and inquiries, we have still not been able to find any information about the SBI MF which she invested in 2005. This was done in cash at that time and we have no clue about the details now. The IEPF database does not seem to work properly in this regard either.

– Preeti Sanghi, Hyderabad • preeti@pragatiplast.com

Nice issues raised by your editorial about Consumers unclaimed money, which government is using in various fields rather than consumer affairs. It should be returned to them/their heirs within three years if consumers are not approaching to inquire or stop depositing premium, EMI. In this regard, awareness program should be launched in association with banks, LIC, etc

– Lavi Tikkha, Lucknow
President, Avadh Upbhokta Hit Sanrakshan Samiti
authenticate58@gmail.com

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WATCH OUT

Watch out for the next issue in October dedicated to "Consumers Right to Repair!"

ONE EARTH – ONE HEALTH

Advantage Healthcare India Conference 2023

17-19 August, 2023

THE CONFERENCE - HOSTED at Gandhinagar alongside the G20 Health Ministers' Meeting - provided NABH-QCI a platform to demonstrate its unwavering commitment to extending quality integrated healthcare to every individual. The NABH-QCI booth was graced with the esteemed presence of key dignitaries - Dr. Mansukh Mandaviya (Hon'ble Minister for Health & Family Welfare, GoI), Dr. Tedros Adhanom Ghebreyesus (Director-General of WHO), Shri Sarbananda Sonowal (Hon'ble Minister for AYUSH), Prof. S.P. Singh Baghel (Hon'ble Minister of State (SPSB) at MoHFW), Dr. Bharati Pravin Pawar (Hon'ble Minister of State (BPP) at MoHFW) and Dr. Mahendrabhai Kalubhai Munjpara (Hon'ble Minister of State at Ministry of Ayush).

They lauded NABH-QCI (represented by Mr. Jaxay Shah, Mr. Ravi P. Singh and Dr. Atul Mohan Kochhar) for the exceptional efforts and encouraged the team to continue their relentless pursuit of ensuring quality healthcare for every segment of society. ■

QUALITY COUNCIL® OF INDIA
Creating an Ecosystem for Quality

NABH PATIENT SAFETY CONFERENCE 2023 (NPSC '23)

World Patient Safety Day is one of WHO's global public health days established in 2019 by the Seventy second World Health Assembly. Each year, a new theme is selected to highlight a priority patient safety area for action. Recognizing the central role that patients, their families and caregivers play in advancing safe care, "Engaging patients for patient safety" has been selected as the theme for World Patient Safety Day 2023. Evidence shows that when patients are treated as partners in their care, significant gains are made in safety, patient satisfaction and health outcomes.

Adopting the message and this year's theme, NABH is organizing a one-day conference with a well-knit structural program to learn and deep dive into all the aspects of patient safety. Register soon to attend this a vibrant forum to exchange ideas and learn from the renowned leaders and experts.

Who should Attend?

- CEOs/ Medical Directors/ Hospital Administrators/ Departmental Heads
- Nursing Leaders/ Superintendents/ Supervisors/ Staff nurses/ Students
- Hospital Quality Teams and healthcare quality experts
- Healthcare Quality and Patient safety enthusiasts
- MHA and MBA students

Registration:

Token registration (Non-refundable and non-changeable):

INR 1000/- + 18% GST (Limited for first 500 registrations)

No on-the spot registration. Certificates will be provided to all the registered participants.

Click the link or scan

QR code for registration:

For more information

Mr. Vikash Chaudhary | +91 11 42600622; +91 9873380280 | vikash@nabh.co

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