EDITORIAL

PATIENT SAFETY AND HEALTHCARE QUALITY - CAN TERTIARY HEALTHCARE INSTITUTIONS IN A DEVELOPING COUNTRY LIKE PAKISTAN PLAY A ROLE?

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The conception of patient safety and healthcare quality can be easily traced back to eminent figures like Ignaz Semmelweis, the obstetrician known as the "savior of mothers" who pioneered antiseptic procedures e.g. hand washing in the 19th century1. Ernest Codman (1869-1940), a surgeon who has eponymic fame for "Codman's tumor", Codman's triangle" and so on, also led the creation of hospital standards and implementation of strategies to assess healthcare outcomes through his idea of results. Systematic and sustainable patient safety and healthcare quality in particular have much shorter and less epic trajectories. It evolved through several extraordinary quality improvement efforts in the later half of the 20th century most of which surfaced through academic papers. Nonetheless, these efforts caught increasing multidisciplinary attention towards deficiencies in healthcare delivery, processes and systems yet rocketed 'patient safety and healthcare quality' from the pen of a group of spearhead academicians to national agendas.

In 1966, Avedis Donabedian, a physician published "Evaluating the Quality of Medical Care"3, a replicable and highly useful model that relies upon the elements of structure, process, and outcomes to examine the quality of care delivered. The Donabedian Model provides a basis for the current methods used to evaluate healthcare quality. The Institute of Medicine (IOM) was established in 1970, and has since focused on evaluating, informing, and improving the quality of healthcare delivered4. In 2000, the seminal publication of the IOM report To Err is Human provided a roadmap towards a safer health system through a four-tier approach: 1) Establishing a national focus to create leadership, research, tools, and protocols to enhance the knowledge base about safety, 2) Identifying and learning from errors by developing a nationwide public mandatory reporting system and by encouraging health care organizations and practitioners to develop and participate in voluntary reporting systems, 3) Raising performance standards and expectations for improvements in safety through the actions of oversight organizations, professional groups, and group purchasers of health care, and 4) Implementing safety systems in health care organizations to ensure safe practices at the delivery level5. This publication stirred the growing interest in improving patient safety and healthcare quality and shaped the strategies, activities, and investments to build safer health systems in the last two decades. In this period, the focus has been on reporting, reviewing, and avoiding bad outcomes – safety seemed to be defined by fewer adverse events and outcomes also known as Safety-I has led to a sustained improvement only in voluntarily reporting of adverse events and agreed to methodologies to review adverse outcome e.g. Root Cause Analysis at least in developed and some parts of developing world. Safety-I approaches have been glacially slow

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in reducing harm rate or probably haven't beaten the pace of changing world health epidemiology and technological advancements in diagnostic and therapeutic measures which only add further complexity. Therefore, an ever-increasing need to focus on quality and safety with even more rigorous approaches is inevitable globally, nationally, and locally – at all levels.

In any reasonable healthcare system, bad outcomes are expected to happen in lesser cases and most cases would have a good, expected outcome. Safety management should therefore move from ensuring that 'as few things as possible go wrong' to ensuring that 'as many things as possible go right'. Erik Hollnagel and co-workers published a white paper on an approach known as Safety-II in 2015 whereby they advocate analysis of the factors which lead a system to work well bringing good outcomes6. A comment on Safety II perspective in this editorial is made as a food for thought – watch this space!

After this brief historic glimpse, I would like to concisely hint towards where to start for healthcare institutions in a developing country like Pakistan? Albeit tertiary healthcare institutions often share a huge chunk of primary and secondary health facilities' work and therefore remain under immense workload at any given point in time, yet they could play a pivotal role towards building safer healthcare systems mainly by implementing some of the Safety I approaches at organisational level: 1) raising awareness about healthcare quality and patient safety at all levels of healthcare professions from medical students to practitioners, 2) introducing local policies, guidelines and checklists for common and complex procedures, 3) establishing incident reporting systems, 4) building local processes to learn from adverse events and 5) become part of the network of patient safety healthcare quality organisations like Institute for Healthcare Improvement and The International Society for Quality in Health Care for sustained growth in knowledge and expertise. These approaches would help tertiary healthcare institutions to build safer health systems, nurture a safety culture, get ready for quality assurance and accreditations, prepare to take the challenge of ever-increasing complexity in healthcare context and to shine at global horizon.

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