



FEDERAL MINISTRY OF HEALTH AND SOCIAL WELFARE

National Patient Safety and Care Quality Policy & Implementation Strategy 2024



FEDERAL MINISTRY OF HEALTH AND SOCIAL WELFARE

National Patient Safety and Care Quality Policy
&
Implementation Strategy 2024

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Foreword

For the first time in our nation's history, the Federal Ministry of Health is taking a groundbreaking step towards fostering a patient safety culture among our dedicated health workers. This policy document not only serves as a guide for healthcare providers but also establishes a framework to uphold the highest standards of care quality within the Nigerian Health system. Aligned with the presidential initiative, this initiative responds to the World Health Assembly's resolution WHA72.6, recognizing Patient Safety as a pivotal component in our journey toward achieving universal health coverage.

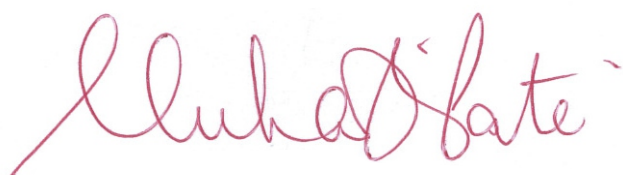
Globally, the World Health Organization reports a distressing number of patients facing harm or even death due to unsafe care, leading to significant mortality and morbidity rates. While Nigeria is earnestly working towards establishing a national system for patient safety incident reporting, the evidence of unsafe care in public and private health institutions is undeniable. Instances brought before the Medical and Dental Council of Nigeria and complaints received by the Federal Competition and Consumer Protection Commission (FCCPC) underscore the urgency of addressing safety concerns. It's crucial to acknowledge that underreporting of safety incidents, a challenge faced even by more developed nations, must be considered. Additionally, the absence of standardized health facility design and construction raises concerns about the working environment's safety for our healthcare workers, exacerbating the risks for patients, families, and communities.

To achieve high-quality care, instill confidence in the health sector, and ensure the safety of medical and surgical procedures, we must rigorously implement and enforce healthcare quality and safety standards across all healthcare institutions. A dedicated care quality and safety team, working in collaboration with existing standards and safety stakeholders, will oversee the monitoring of these standards at both new and existing healthcare facilities.

This National Policy on Patient Safety and Care Quality adheres to global best practices, tailored to suit the Nigerian context. I urge all stakeholders, especially at the facility level, to familiarize themselves with this policy. In furtherance of our commitment, the government plans to establish a robust Care Quality team, aligning with our overarching agenda—Improving Population health outcomes, Medical Industrialization, Health Security/Pre-pandemic preparedness, and Health Governance. Together, we aim to accelerate the realization of Universal Health Coverage and contribute significantly to the Sustainable Development Goals in Nigeria.

As we embark on this transformative journey, let us unite in our commitment to providing safer, higher-quality healthcare for the benefit of every Nigerian citizen.

Sincerely,



Prof. Muhammad Ali Pate, CON
Co-ordinating Minister of Health and Social Welfare

Acknowledgment

The Federal Ministry of Health (FMOH) expresses her profound appreciation for the remarkable determination and support received from all stakeholders such as Departments and Agencies, Donors as well as partners that participated in the process of the development of this National Policy and Strategy on Patient Safety and Care Quality in Nigeria (2024 to 2029).

Indeed, this document is novel in the Country. The multi-sectoral and multi-stakeholder consultative approach has therefore provided wide perspectives and technical insights in the development of a clear policy and strategy, which serve as standards to judge practices. The primary goal of this policy is to reduce morbidity and mortality resulting from medical errors in Nigeria; by addressing the key barriers restraining access to quality health care services free of error in our health care facilities in the next five years and beyond. These stakeholders have focused their attention on developing strategy that will achieve the stated goals.

The Ministry specifically recognises the invaluable commitment and contributions from the technical writing group and partners who have supported this process. These include but not limited to:

- Clinton Health Access Initiative (CHAI)
- Dr. Ameyo Stella Adadevoh (DRASA) Health Trust
- Federal Ministry of Health and Social Welfare (Patient Safety Desk)
- Patient Safety Africa
- SERVICOM
- West African Institute of Public Health
- World Health Organization (WHO)



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Acronyms

A&E	Accident and Emergency
AFR/RC58/8	Fifty-eighth session of the WHO Regional Committee for Africa
CSO	Civil Society Organisation
FMoH	Federal Ministry of Health
IPC	Infection Prevention and Control
MCH	Maternal and Child Health
MDA	Ministries, Departments and Agencies
NGO	Non-Governmental Organisations
NHIA	National Health Insurance Authority
NHIS	National Health Insurance Scheme
NIMR	Nigerian Institute of Medical Research
NSHDP	National Strategic Health Development Plan
NSW	New South Wales
PEP	Post Exposure Prophylaxis
PPE	Personal Protective Equipment
SDG	Sustainable Development Goals
SO	Strategic Objectives
UHC	Universal Health Coverage
UN	United Nations
UNFPA	United Nations Population Fund (formerly United Nations Fund for Population Activities)
UNICEF	United Nations Children's Fund (formerly United Nations International Children's Emergency Fund)
WHA	World Health Assembly
WHO	World Health Organization



Definition of terms

Patient safety

Patient safety is a framework of organized activities that creates cultures, processes, procedures, behaviours, technologies and environments in health care that consistently and sustainably lower risks, reduce the occurrence of avoidable harm, make errors less likely, and reduce its impact when it does occur, (WHO 2021).

Quality of care

The degree to which health services for individual and populations increase their likelihood of desired health outcomes and are consistent with current professional knowledge, (Institute of Medicine, 1990).

Risk

The probability of danger, loss, or injury within the healthcare system

Incident

Any unintended or unexpected occurrence that could have led to harm or did lead to harm for any one or more persons' receiving healthcare. A patient safety incident is any unplanned or unintended event or circumstance which could have resulted or did result in harm to patients and caregivers. This includes harm from an outcome of an illness or its treatment that did not meet the patient's or the clinician's expectation for improvement or care. (NSW Health Incident Management Policy)

Health service

Any service (not limited to medical or clinical services) aimed at contributing to improved health or to the diagnosis, treatment, and rehabilitation of individuals and populations.

Error

Failure to carry out a planned action as intended or application of an incorrect plan (WHO Action Plan)

Harm

Impairment of structure or function of the body and/or any deleterious effect arising there from; harm includes diseases, injuries, psychological suffering, disability and death (WHO Action Plan)

Hazard

A circumstance, agent, or action with the potential to cause harm (WHO Action Plan)

Adverse event

An incident which resulted in harm to a patient or patients (WHO Action Plan)

Caregivers

Individuals who provide care for a member or members of their family, friends, or community; may provide regular, occasional, or routine care or be involved in organizing care delivered by others (WHO Action Plan)

Clinical Governance

A framework through which healthcare organizations are accountable for continually improving the quality of their service and safeguarding high standards of care by creating an environment in which excellence in clinical care will flourish.

Complication

A disease or injury that arises subsequent to another disease and/or healthcare intervention (WHO Action Plan)

Adverse drug event

Any injury resulting from medical interventions related to a drug. This includes both adverse drug reactions in which no error occurred and complications resulting from medication errors (WHO Action Plan)

Medication error

Any preventable event that may cause or lead to inappropriate medication use or patient harm while the medication is in the control of the health care professional, patient, or consumer (WHO Action Plan)

National Patient Safety Policy

A formal government statement that defines priorities and parameters for action in response to a country's needs, available resources (including technological), and political considerations, and that is developed in close consultation with stakeholders, including communities (WHO Action Plan)

Near Miss

Any incident that had the potential to cause harm but was prevented and so no harm was caused to the patient (NPSA, 2010)

Never event

A patient safety incident that results in serious patient harm or death (this refers to particularly shocking medical errors - such as wrong-site surgery, that should never occur) (WHO Action Plan).

No harm incident

Any patient safety incident that occurred but no discernable harm resulted.

Harmful incident (adverse event)

An incident that results in harm to a patient that is related to medical management, in contrast to disease complications or underlying disease

Incident type

A descriptive term for a category made up of incidents of a common nature, grouped because of shared, agreed features.

System

A set of interdependent elements (people, processes, equipment) that interact to achieve a common aim. (*Oxford Dictionary*)

Incident outcomes

All impacts upon a patient or an organization wholly or partially attributable to an incident.

Organisational outcome

The impact upon an organization that is wholly or partially attributable to an incident.

Patient outcome

The impact upon a patient that is wholly or partially attributable to an incident or intervention.

Resulting actions

Identify immediate or indirect actions taken that relate to the patient or the organization to improve the situation or prevent the reoccurrence of an incident.

Minimal information model

Refers to a minimal common architecture for the core concepts considered to be essential for information and comparison purposes for Patient Safety Incident (PSI) reports.



Executive Summary

Introduction

This policy document addresses the persistent challenge of unsafe care and patient harm in the Nigerian health service. Emphasizing the global significance of patient safety, the Federal Government of Nigeria has developed a strategic approach to align with international resolutions. The document underscores the historical events leading to its formulation and aligns with WHO resolutions and global initiatives for patient safety. The rationale highlights the essential role of patient safety and quality of care in achieving Universal Health Coverage and Sustainable Development Goals. The development process involved a comprehensive analysis, stakeholder engagement, and validation. The document is designed to guide various stakeholders and is grounded in guiding principles focused on quality, standardization, incident management, safety culture, sustainability, and risk management. Overall, the policy aims to foster a patient safety culture and contribute to global efforts outlined in the WHO Global Patient Safety Action Plan 2021–2030.

Policy statement

The National Patient Safety and Care Quality Policy aims to accelerate system-wide improvements in healthcare, aligning with WHO objectives. It consolidates stand-alone guidelines, focusing on priority areas like professional knowledge and learning, infection control, medication safety, and patient engagement. The scope emphasizes collective responsibility, involving diverse stakeholders. The policy sets binding obligations for government and stakeholders, commits to comprehensive healthcare system improvement, prioritizes public awareness, and underscores professional excellence. Specific objectives include establishing robust patient safety systems, promoting reporting and learning, reducing healthcare-associated infections, optimizing medication safety, empowering patients, and fostering multisectoral collaboration. The policy outlines a comprehensive situation analysis, addressing challenges and opportunities, with a focus on data collection, staffing, and non-punitive responses to errors. The five-year strategy aligns with global standards, emphasizing patient and staff expectations, regulatory framework enhancement, and the need for political will to drive transformative changes in quality care delivery.

Legal framework

The National Patient Safety and Care Quality Improvement policy in Nigeria is firmly anchored within the legal framework, including the Constitution of the Federal Republic of Nigeria, the National Health Act 2014, National Health Insurance Authority (NHIA) Act 2022, Patients' Bill of Rights 2018, National Strategic Health Development Plan II, National Policy on Injection Safety and Healthcare Waste Management, Child Rights Act 2003, National Policy for Infection Prevention and Control, and the Occupational Health and Safety Bill 2012, Nigeria Data Protection Act 2023, The Nigerian National Mental Health Act, 2021. These legal foundations speak to the right to life, government's responsibility for security and welfare, access to quality healthcare, patient rights, and the promotion of health and safety in healthcare settings. The policy aligns with these laws to ensure a comprehensive and legally sound approach to patient safety and care quality.

Strategic framework

The National Patient Safety and Care Quality Policy outlines a strategic framework focused on eradicating preventable harm, building high reliability health systems, ensuring the safety of clinical processes, and improving maternal outcomes. Rooted in a commitment to excellence and safety, the policy aims to integrate safety into every aspect of healthcare, engage patients as partners, and empower healthcare workers. The collective commitment involves collaboration with various stakeholders to create a healthcare system prioritizing patient safety, clinical excellence, and client satisfaction. The ultimate vision is a Nigeria where every individual receives healthcare that not only heals but also protects, ensuring the safety and empowerment of both patients and healthcare workers.

Monitoring and evaluation

The Monitoring and Evaluation section of the National Patient Safety and Care Quality Policy outlines the Monitoring and Evaluation framework with the goal of assuring patient safety and achieving zero avoidable harm in healthcare. The framework includes key components such as performance indicators, data collection methods, analysis, reporting, and continuous improvement mechanisms. Key performance indicators encompass tracking adverse events, compliance with clinical guidelines, medication error rates, healthcare-associated infection rates, patient safety culture surveys, readmission rates, and surgical complication rates. Data collection methods include incident reporting systems, clinical audits, patient interviews, surveys, and root cause analyses. The analysis and reporting section lays emphasis on regular data analysis, quarterly and annual reports, and benchmarking against industry standards. Continuous improvement mechanisms include feedback loops, quality improvement initiatives, and training programs. The section on responsibilities and accountability stresses the need for clear roles within healthcare organizations. Finally, the chapter underscores the importance of periodic reviews and adaptations to ensure the framework's relevance and effectiveness in evolving healthcare environments.



CHAPTER ONE

BACKGROUND

Ensuring patient safety remains the paramount focus of healthcare services, guided by the principle of "First Do No Harm." Regrettably, despite the preventability of most harms, unsafe care and patient injuries persist in the Nigerian health service and globally (WHO, 2000). The impact of healthcare harm extends beyond the individual level, affecting families and imposing substantial economic burdens on developing economies like Nigeria. Additionally, these issues hinder progress toward Universal Health Coverage and the Sustainable Development Goals.

In response to global and African resolutions on patient safety (WHA55.18, 2002; AFR/58/RC/8, 2008; WHA72.6, 2019), the Federal Government of Nigeria has taken a decisive step in crafting a strategic patient safety and care quality roadmap. This initiative aims to foster continuous quality improvements, institutional and organizational clinical audits, and governance goals to establish a patient safety culture.

Patient safety, as defined by WHO in 2021, encompasses organized activities fostering cultures, processes, behaviours, and technologies that consistently lower risks and reduce avoidable harm in healthcare. It aims at making healthcare safer for both patients and healthcare workers. (Kohn L, Corrigan J, Donaldson M, 2000). This policy emphasizes the organizational, managerial, economic, and clinical aspects of patient safety.

1.0 Historical Events Leading to the Policy Document

In May 2002, the Fifty-fifth World Health Assembly adopted resolution WHA55.18. This urged Member States to pay the closest possible attention to the problem of patient safety and to establish and strengthen science-based systems necessary for improving patient safety and the quality of healthcare. Two years later in May 2004, the Fifty-seventh World Health Assembly supported the creation of an international alliance to facilitate the development of patient safety policy and practice in all Member States and to act as a major force for improvement globally. Historical milestones, such as the adoption of resolutions WHA55.18 (2002), AFR/RC58/8 (2008), and WHA72.6 (2019), laid the foundation for a coordinated approach to patient safety. The Federal Ministry of Health's efforts since 2011, culminating in the National Health Act (2014), signify a commitment to prioritizing patient safety and care quality.

The resolution WHA72.6 in 2019 underscored global action on patient safety, aligning with Universal Health Coverage and the Sustainable Development Goals. This national policy document and its Implementation Strategy aim to support the effective implementation of the WHO Global Patient Safety Action Plan 2021–2030 in Nigeria.

1.1 Rationale

Patient Safety and Care Quality are fundamental to healthcare and crucial for achieving Universal Health Coverage and Sustainable Development Goals. A strategic and coordinated approach is necessary, involving a national commitment and a thorough development process. This process included a national patient safety situation analysis (review of existing national policy documents, identification of patient safety gaps at all levels of the health service); stakeholder engagement, community involvement, funding, and validation.

1.2 Intended Use of this Document

This document serves as a guide for various stakeholders, including federal and state health ministries, healthcare facilities (public and private), administrators, workers, policy planners, partners, professional organizations, donor agencies, regulatory bodies, maintenance organizations, NGOs, academic institutions, and communities.

1.3 Guiding Principles

This policy document is centered on engaging patients and their families as partners in safe care practices, utilizing data for actionable improvements. The guiding principles include a focus on quality, standardization, incident management based on a "just culture," safety culture institutionalization, sustainability, and risk management to ensure the safety of patients, healthcare workers, and visitors.



CHAPTER TWO

THE POLICY STATEMENT

The National Patient Safety and Care Quality Policy document describes a path for accelerating system-wide improvements using a National Strategy guided by objectives outlined by WHO namely;

- ❖ **Eliminate avoidable harm in healthcare to patients**
- ❖ **Build high-reliability health systems that protect patients**
- ❖ **Assure the safety of every clinical process**
- ❖ **Promote patient engagement**
- ❖ **Educate health workers on skills and safety**
- ❖ **Ensure adequate information and research to promote risk management**
- ❖ **Develop and sustain multi-sectoral synergy and partnership to improve patient safety**

The National Patient Safety and Care Quality Policy and Strategy document has been developed to harmonize the several stand-alone guidelines such as Injection Safety, Do no Harm, Infection Prevention and Control, Blood Safety, Health Care Waste Management Policy, etc., which prioritize improvement interventions that are likely to have an impact on patient safety.

2.0 Priority areas for action

The following section provides an overview of the prioritized strategic intervention areas:

- ❖ Knowledge and learning in patient safety including continuing professional development of healthcare workers
- ❖ Patient safety awareness raising at national and sub-national levels
- ❖ Healthcare-associated infections and Infection prevention and control (IPC)
- ❖ Health worker protection
- ❖ Healthcare waste management
- ❖ Safe surgical care
- ❖ Medication safety
- ❖ Patient safety partnerships
- ❖ Financing and sustainability
- ❖ Patient safety surveillance and research

2.1 Scope

Patient safety is a collective responsibility, necessitating active engagement from a diverse array of stakeholders, including patients, their families, governmental bodies, non-governmental organizations (NGOs), professional associations, and more. This policy document serves as a cornerstone for enhancing patient safety, clinical outcomes, and client satisfaction across all tiers of healthcare delivery in Nigeria.

2.1.1 Binding Obligations for Government and Stakeholders

This policy holds binding implications for Government Ministries, Departments, and Agencies (MDAs) at both the national and state levels, as well as an extensive spectrum of stakeholders. These stakeholders encompass NGOs, regulatory authorities, professional associations, scientific societies, academic and research institutions, and civil society organizations. Compliance with this policy underscores our collective commitment to elevating patient safety standards and upholding the highest quality of care.

2.1.2 Comprehensive Healthcare System Commitment

Our healthcare system, spanning from the federal level to local communities and encompassing both public and private sectors, will demonstrate an unwavering commitment to patient safety and the mitigation of harm. This commitment extends to nurturing a culture of continuous improvement and innovation in healthcare delivery, all driven by the shared goal of safeguarding patient well-being.

2.1.3 Public Awareness and Demonstrable Progress

The broader public will bear witness to and experience a nationwide initiative aimed at enhancing clinical outcomes, supported by tangible and quantifiable results. Transparency and accountability will underpin our endeavors, ensuring that the public remains informed and actively engaged in the quest for enhanced patient safety.

2.1.4 Professional Excellence and Patient-Centric Care

Healthcare professionals within our healthcare system shall prioritize patient safety by providing compassionate, respectful care that upholds patients' rights and responsibilities. These professionals will consistently exceed the expectations of patients and their families, placing the patient experience at the forefront of healthcare delivery.

In embracing these commitments and imperatives, the aim is to propel Nigeria's healthcare system toward an era of excellence in patient safety, clinical outcomes, and client satisfaction, in line with global best practices.

2.2 The Policy

This document is intended to provide a clear strategic direction, delineating concrete actions to be taken by all parties outlined in section 2.2. These actions are designed to facilitate the implementation of the World Health Assembly Resolution (WHA72.6) and, in doing so, strengthen Nigeria's healthcare systems. Our objective is to ensure that our healthcare systems, while striving to fulfill the age-old tenet of "first, do not harm" as articulated by the Greek Physician, Hippocrates (460–375 BC), align with the guidelines set forth in the WHO's guide for developing National Patient Safety Policy and Strategic Plan.

Through this policy, efforts to diagnose, treat, cure, and care for our citizens while steadfastly adhering to the imperative of patient safety will be successful. Implementing this policy, shall foster an environment in which excellence in healthcare will flourish at all levels of care (clinical governance).

2.3 Policy Objectives

2.3.1 General Objective

The key objective of this policy is to guide the effective implementation and institutionalization of the Patient Safety and Care Quality Program, and funding in health facilities to improve safety in health service delivery. The policy sets out the Government's plan to assure quality in health care and to continuously improve the care that is being provided by healthcare workers.

2.3.2 Specific Objectives

1. **Establish Robust Patient Safety Systems:** Develop and implement comprehensive patient safety systems and protocols across all levels of healthcare delivery in Nigeria, with a focus on prevention, detection, and mitigation of patient harm.
2. **Promote a Culture of Reporting and Learning:** Encourage a culture of transparent incident reporting and learning from adverse events, fostering an environment where healthcare workers are encouraged to report errors without fear of punitive action (Just Culture).
3. **Promote the reduction of Healthcare-Associated Infections** through the implementation of robust infection prevention and control measures to significantly reduce healthcare-associated infections, protecting both patients and healthcare workers.
4. **Optimize Medication Safety:** Develop and enforce medication safety protocols to minimize medication errors, including prescription, administration, and monitoring, in order to safeguard patient well-being.
5. **Empower and Engage Patients and Families:** Promote patient and family engagement in healthcare decision-making, care planning, and safety initiatives, ensuring patients are active participants in their own care.
6. **Measure and Evaluate Patient Safety Metrics:** Develop and implement standardized metrics for assessing patient safety and quality of care, with regular evaluations to track progress and identify areas for improvement.
7. **Foster Multi-sectoral Collaboration:** Establish and strengthen partnerships among government agencies, NGOs, professional organizations, research institutions, and other stakeholders to collectively improve patient safety and healthcare quality.
8. **Enhance Public Awareness:** Conduct public awareness campaigns to educate the population about patient safety, their rights, and the importance of their active involvement in ensuring their safety.
9. **Strengthen Regulatory Oversight:** Enhance regulatory oversight of healthcare facilities to ensure compliance with patient safety standards, including regular inspections and enforcement of safety protocols.
10. **Drive Research and Knowledge Sharing:** Encourage and support research on patient safety and the dissemination of best practices and evidence-based guidelines to continuously improve care delivery.

11. Measure Patient Safety Metrics and Monitor, Evaluate, and Report Progress: Develop and implement standardized metrics for assessing patient safety and quality of care, including a robust monitoring and reporting system to track the implementation and impact of patient safety initiatives, sharing progress and outcomes with relevant stakeholders.

12. Advocate to Federal, State, and Local Governments to demonstrate strong political commitment by integrating patient safety programmes in Annual Operational Plan (AOP). This will strengthen the mobilisation of sustainable funding through public mechanisms like Drug Revolving Funds (DRFs) and the National Health Insurance Authority (NHIA); partnerships with private sector stakeholders, international and national development agencies, and philanthropic organizations.

2.4 Situation Analysis

This section presents a comprehensive situation analysis, offering insights into the current state of patient safety and healthcare quality in Nigeria. It underscores the imperative for this policy by highlighting key challenges and opportunities for improvement.

Population and Healthcare Disparities: As of 2020, Nigeria's population exceeded 200 million making it one of the most populous countries globally (Source: National Bureau of Statistics). However, healthcare resources, particularly the ratio of healthcare workers to the populace, exhibit substantial disparities, rendering patients vulnerable to suboptimal and unsafe care practices. The burden of death and disability in Nigeria is largely attributed to unsafe healthcare practices, with adverse events stemming from such practices ranking among the leading global causes of morbidity and mortality.

Alarming statistics from the World Health Organization (WHO) suggest that about 1 in every 10 patients suffer harm in healthcare settings and more than 3 million deaths occur yearly due to unsafe care, a substantial portion of these harms (about 50%) are preventable. This alarming trend is particularly worse in low-middle-income countries, where an estimated 4 in 100 patients die from unsafe care.

Comprehensive Data Base: The last ten years have seen a huge improvement in the collection of data on patient harm in Nigeria by several organisations, however, gaps exist. In order to make the best use of these gains, there is a need to develop a comprehensive repository of national patient safety data that is easily accessible and available to all stakeholders. This will promote the country's ability to gauge the full extent of adverse events and their management, thereby perpetuating an environment of preventable morbidity and mortality resulting from suboptimal patient safety practices.

Common Patient Safety Challenges in Nigeria: Numerous factors contribute to poor patient safety in Nigeria, including clinical errors (such as surgical, medication, and diagnostic errors), healthcare-associated infections, workforce deficiencies, emergency management challenges, inadequate or inappropriate medical equipment, poor communication, inaccessibility of critical health personnel, underreporting of clinical errors, failures in management systems (standard operative procedures, incident management systems, emergency response plans and inadequate funding, etc.).

Safety Culture: Unfortunately, majority of our hospitals still have a blame culture which makes staff hide errors and discourages them from reporting incidents. Transparency and full disclosure of incidents (duty of candor) should be encouraged by supporting staff who make unintended errors with adequate training to forestall future occurrences while those who make intended errors are made to account for their malpractice (just culture).

Focus Areas and Policy Rationale: To address these challenges, The National Patient Safety Policy and Strategy adopts a comprehensive approach. It targets key clinical areas, healthcare worker attitudes, skills, knowledge, infrastructure, human resources for health, medical errors, healthcare-related adverse events, preventable harm, therapeutic errors, diagnostic errors, surgical errors, and drug-related incidents. These interventions are grounded in evidence-based practices and can significantly lower morbidity and mortality rates, given the necessary political support.

Policy's Unifying Framework: This policy serves as a unifying framework to tackle ongoing public health challenges while strengthening Nigeria's healthcare system to respond effectively to evolving healthcare pressures. It places particular emphasis on Maternal and Child Health (MCH) and Emergency Care as entry clinical areas to address identified issues. However, its principles extend to comprehensive quality improvement across the healthcare spectrum.

Five-Year Strategy: The National Patient Safety and Care Quality Policy and Strategy outlines actionable improvement interventions for the next five years, spanning from 2024 to 2029. These initiatives align with the WHO Global Action Plan on Patient Safety for 2021-2030, further reinforcing our commitment to global patient safety standards.

Patient and Clinical Staff Expectations: Future endeavors will prioritize patient and patient safety advocacy group engagement to ensure clean and safe care environments, compassionate and respectful care, and the assurance that patients leave hospitals in improved condition. This document is intended to achieve three fundamental outcomes: "do not harm me," "heal me," and "treat me kindly." Additionally, healthcare professionals seek a streamlined system that "makes it easy to do the right thing," discouraging behaviors that may inadvertently compromise patient safety.

Regulatory Framework Enhancement: In the course of developing this National Patient Safety and Care Quality Policy and Strategy, regulatory bodies expressed a desire to review existing regulatory policies, shifting focus from punitive measures towards learning for continuous quality improvement as well as professional development and support.

Holistic Approach and Political Will: To drive large-scale quality improvement, this policy underscores the need to concentrate on interventions encompassing various dimensions, including disease areas, healthcare worker attitudes, skills, knowledge, equipment, infrastructure, human resources, medical errors, healthcare-related adverse events, preventable harm, therapeutic errors, diagnostic errors, surgical errors, and drug-related incidents.

Future Alignment and Prioritization: The policy document charts a path forward to align diverse stakeholder groups around prioritized interventions over the next five years, setting the stage for transformative changes in quality care delivery.

This Policy provides a roadmap to elevate the healthcare system, enhance patient safety, and ultimately improve clinical outcomes and client satisfaction, in consonance with global patient safety standards and best practices.

CHAPTER THREE

LEGAL FRAMEWORK

The National Patient Safety and Care Quality Improvement policy is set within the framework and subject to the following:

Constitution of the Federal Republic of Nigeria 1999 (as amended)

- ❖ Chapter IV No 33.1 Every person has a right to life, and no one shall be deprived intentionally of his life.
- ❖ Chapter II 14 (2b) The security and welfare of the people shall be the primary purpose of government.
- ❖ 24(c) Respect the dignity of other citizens and the rights and legitimate interests of others.

National Health Act 2014

- ❖ Provide for persons living in Nigeria, the best possible health services within the limit of available resources.
- ❖ Set out the rights and obligations of health care providers, health workers, health establishments and users, and the highest policy body.
- ❖ Protect, promote, and fulfill the rights of the people of Nigeria to have access to healthcare services.

National Health Insurance Authority Act 2022

- ❖ Ensure that every Nigerian has access to quality health care services
- ❖ Maintain high standard of health care delivery services within the Scheme
- ❖ Ensure efficiency in health care services
- ❖ Ensure and assist the authority in achieving Universal Health Care Coverage to all Nigerians.

Patients' Bill of Rights 2018

- ❖ Patients' right of access to information, quality of care and dignity
- ❖ Right to privacy and confidentiality of patient records
- ❖ Right to receive urgent, immediate and sufficient intervention and care in the event of an emergency
- ❖ Right to complain and express dissatisfaction regarding services received

National Data Protection Act 2021

- ❖ Safeguard the fundamental rights and freedoms, and the interests of data subjects, as guaranteed under the Constitution of the Federal Republic of Nigeria, 1999
- ❖ Provide for the regulation of the processing of personal data
- ❖ Promote data processing practices that safeguard the security of personal data and privacy of data subjects
- ❖ Ensure that personal data is processed in a fair, lawful and accountable manner Protect data subjects' rights, and provide means of recourse and remedies, in the event of the breach of the data subject's rights

Mental Health Act 2021

- ❖ Promote and protect the fundamental human rights and freedom of all persons with mental health conditions and ensure that the rights are guaranteed
- ❖ Promote the implementation of approved national minimum standards for mental health services in Nigeria
- ❖ Promote recovery from mental health conditions and enhance rehabilitation and integration of persons with mental health conditions into the community

National Strategic Health Development Plan II

- ❖ Provide effective leadership and an enabling policy environment that ensures adequate oversight and accountability for the delivery of quality healthcare.
- ❖ Improve health outcomes through prompt and effective response to 24-hour medical emergencies.
- ❖ Improve the wellbeing, safety and quality of life of Nigerians through health promotion and healthy environment
- ❖ Ensure that quality medicines, vaccines, and other health commodities and technologies are available, affordable and accessible to all Nigerians

National Policy on Injection Safety and Healthcare Waste Management, FMoH 2007

- ❖ To protect/or minimize the risks due to unsafe injection and healthcare waste management practices to the patients, health workers and consumers.

Child Rights Act 2003 (Section 13)

- ❖ Every child is entitled to enjoy the best attainable state of physical, mental and spiritual health
- ❖ Every government, parent, guardian, institution, service, agency, organization or body responsible for the care of a child shall endeavor to provide for the child the best attainable state of health.

National Policy for Infection Prevention and Control, FMoH 2013

- ❖ Prevention and control of infections within healthcare settings should be provided so as to enable the safety of patients, health workers and the community.

Occupational Health and Safety Bill 2012

- ❖ Provision of a safe work environment for health workers



CHAPTER FOUR

IMPLEMENTATION STRATEGY

4.0 Strategic Framework

In pursuit of a brighter and healthier future for all, the National Patient Safety and Care Quality Policy document lays the foundation for comprehensive and transformative changes within the healthcare landscape. Rooted in a commitment to excellence, safety, and compassion, this policy serves as a guiding light for healthcare organizations, practitioners, and stakeholders across the nation.

The strategic objectives are clear, and strengthened by an unwavering dedication to the well-being of every individual who seeks medical care. The collective mission encompasses a range of critical goals, each designed to address the unique challenges faced within the Nigerian healthcare system.

The strategic plan aims to "Make zero avoidable harm to patients a state of mind and a rule of engagement in the planning and delivery of healthcare everywhere." (Lachman et al, 2022)

This objective underscores our commitment to eradicating preventable harm, fostering a culture of safety, and prioritizing patient-centered care. To achieve these, strategies are employed to integrate safety into every facet of healthcare, from prescribing medications to administering treatments.

Building upon these core objectives, this policy and strategic document also aims to "Build high-reliability health systems and health organizations that protect patients daily from harm."

The country seeks to create healthcare environments that consistently prioritize patient safety, minimizing the risk of errors and adverse events, through meticulous planning, rigorous training, and quality control.

A key principle of this plan is to be resolute in the pursuit of assuring the safety of every clinical process, whether it be through infection prevention and control, healthcare waste management, or medication safety. The strategies encompass comprehensive guidelines, robust training programs, and monitoring to ensure that every aspect of clinical care adheres to the highest safety standards.

Additionally, the strategy lays the roadmap to "Improve maternal outcomes for all pregnant women," recognizing the crucial importance of maternal health. Through early, accessible prenatal care, skilled birth attendance, and comprehensive family planning services, the aim is to reduce maternal mortality and enhance the overall wellbeing of expectant mothers.

The strategies in this document impose a collective commitment that extends to fostering a healthcare system that not only meets the highest standards of safety and quality but also engages patients and their families as active partners in care. It seeks to empower healthcare workers with the knowledge and tools necessary to deliver compassionate, respectful care that exceeds the expectations of patients and their loved ones.

In collaboration with government agencies, non-governmental organizations, regulatory bodies, professional associations, and the broader community, this policy charts a course toward a healthcare system that prioritizes patient safety, clinical excellence, and client satisfaction. This plan envisions a Nigeria where every individual receives healthcare that not only heals but also protects, where every patient is assured of their safety, and where every healthcare worker is supported to deliver the best care possible.

4.1 Integration of Technology and Innovation

Technology and innovation are critical for the effective implementation of this patient safety and care quality and strategy document. Enhancing patient management, monitoring, timely referrals, and the review of laboratory results through the use of technology will ensure safer and more efficient care delivery.

This section outlines the key areas where technology integration will support health goals and the necessary steps for successful implementation. The advantages of these include: Care integration, timeliness of care, confidentiality and value in environmental sustainability, and reduction in medication errors.

Medical records: The adoption of Electronic Medical Records (EMRs) is a cornerstone of this strategy. This transition will reduce reliance on paper for medical records, and mitigate the risk of records being carelessly handled within hospital settings.

EMRs offer several benefits, including:

- ❖ Care Integration - Seamless sharing of patient information across different care providers.
- ❖ Timeliness of Care - Immediate access to patient data for faster decision-making.
- ❖ Confidentiality and Security - Enhanced protection of patient information.
- ❖ Environmental Sustainability - Reduced reliance on paper records.
- ❖ Reduction in Medication Errors - Accurate and up-to-date patient medication histories.

Substantial investments in infrastructure, such as computers and staff training, are required to support this transition.

Acute Care: Technological tools like Maternal Early Warning Scores (MEWS) and Early Warning Scores (EWS) will be employed to monitor and respond to patient deterioration. Additionally, customized monitoring systems for rural settings and telemedicine platforms will enhance the reach and responsiveness of care in underserved areas.

Medication safety: Technology will be deployed for drug identification to inform prescriptions and the documentation of drug administration and storage including medication reconciliation and allergy checks

Surgical safety: Available technology will support surgical patient identification and surgical safety protocols including consenting.

Diagnostics: Technology supports diagnostic services in areas of sample identification and laboratory results acknowledgments which will reduce failure to treat. Automatic dose management technology will help reduce harm arising from diagnostic radiology, interventional radiology, nuclear medicine, and radiotherapy procedures. Advanced technology will support diagnostic services by:

- ❖ Sample identification - Ensuring accurate laboratory results.
- ❖ Timely acknowledgment - Reducing treatment delays.
- ❖ Radiation safety - Automatic radiation dose management.

Patient referral and communication between healthcare providers and patients are crucial.

Technology will facilitate:

- ❖ Timely referrals - Efficient transfer of patients between facilities.
- ❖ Telemedicine - Remote consultations to improve access to healthcare, especially in underserved communities.

Technology will play a critical role in e-learning, a vital component of continuous quality improvement.

E-learning platforms will facilitate continuous quality improvement, training, and education for healthcare professionals.

CHAPTER FIVE

HEALTHCARE EMERGENCY PREPAREDNESS AND MANAGEMENT

In the complex and dynamic field of healthcare, effective crisis management and emergency preparedness are essential for safeguarding patient safety and ensuring the continuity of care.

This section of the document outlines the importance, objectives, key components, implementation strategy, and monitoring mechanisms of crisis management and emergency preparedness within our healthcare system. The proposed framework aims to ensure readiness and foster continuous improvement to mitigate risks, enhance response capabilities, and maintain the highest standards of healthcare delivery.

Outbreaks are unpredictable and are not everyday occurrences. Most emergencies on the other hand occur with relative frequency. This document provides for patient safety in these circumstances; and is covered by ***Strategic Objective 3: Assurance of Safety of Clinical Process***

5.0 Importance of Crisis Management and Emergency Preparedness

Crisis management and emergency preparedness are critical in healthcare to handle unexpected events that can significantly disrupt operations and patient care. These measures are vital in minimizing the impact of disasters, pandemics, and other emergencies, ensuring that healthcare facilities remain functional, and patients receive timely and effective care. This section provides a structured approach to developing and maintaining robust crisis management and emergency preparedness protocols.

Objectives

The primary objectives of crisis management and emergency preparedness are to:

- ❖ Identify and mitigate risks that may compromise healthcare delivery.
- ❖ Develop and maintain a comprehensive Emergency Response Plan (ERP).
- ❖ Establish effective communication protocols for timely information dissemination.
- ❖ Define clear roles and responsibilities for staff during emergencies.
- ❖ Provide regular training and education to enhance preparedness.
- ❖ Ensure the availability and proper allocation of essential resources.
- ❖ Foster collaboration and partnerships with relevant agencies.
- ❖ Implement continuous improvement mechanisms based on feedback and evaluations.

5.1 Key Components

Risk Assessment and Mitigation

- ❖ Conduct thorough risk assessments to identify potential threats.
- ❖ Develop and implement strategies to mitigate identified risks.

Emergency Response Plan (ERP)

- ❖ Create and maintain a detailed ERP.
- ❖ Regularly conduct drills and simulations to test and refine the ERP.

Communication Protocols

- ❖ Establish robust communication channels for internal and external stakeholders.
- ❖ Develop a comprehensive communication plan to ensure timely and accurate information flow.

Roles and Responsibilities

- v Clearly define roles and responsibilities for all staff members during emergencies.
- ❖ Form an emergency management team to coordinate response efforts.

Training and Education

- ❖ Provide regular training programs to ensure staff are well-prepared for emergencies.
- ❖ Include crisis management and emergency preparedness in onboarding processes for new employees.

Resource Management

- ❖ Ensure the availability of critical resources, including medical supplies and equipment.
- ❖ Plan for efficient resource allocation during emergencies.

Collaboration and Partnerships

- ❖ Establish partnerships with local, national, and international agencies.
- ❖ Participate in joint exercises to enhance coordination and response capabilities.

Implementation Strategy

- ❖ Developing the ERP
- ❖ Engage stakeholders in the development process.
- ❖ Review and approve the ERP, ensuring it aligns with best practices and regulatory requirements.

Training and Drills

- ❖ Schedule regular training sessions for all staff members.
- ❖ Evaluate and revise the ERP based on outcomes from drills and simulations.

Monitoring and Evaluation

- ❖ Continuously monitor the implementation of the ERP.
- ❖ Conduct after-action reviews to identify lessons learned and areas for improvement.

Continuous Improvement

- ❖ Establish a feedback loop to gather input from staff and stakeholders.
- ❖ Regularly review and update the ERP to incorporate new insights and emerging best practices.

Documentation and Reporting

- ❖ Maintain accurate records of all crisis management and emergency preparedness activities.
- ❖ Develop a reporting system to ensure transparency and accountability.

5.2 Health Workers Mental Health and Wellbeing

Mental health issues are highly prevalent among today's adults in all kinds of workplaces. Stress is a strong indicator of workplace mental health and has been predicted to worsen as a result of advancements in technology. According to the World Health Organization, decent work is good for mental health and the need for a healthy work environment has become highly imperative globally.

The Burden of Mental Health

One in six working-age adults has symptoms associated with mental health and this adversely affects employees' health and well-being which translates into risks of potential harm to patients in the healthcare system.

Inclusion of Mental Health into existing Healthcare Policies

The COVID-19 Pandemic pointed the entire world to the importance of employees' mental health within the healthcare value chain. The need to include mental health in existing policies in healthcare systems and facilities becomes very apparent. A clear mental health policy is a crucial and effective tool to deploy in any health ministry. When well-designed and put into action through plans and programs, it can greatly improve the population's mental health.

The following are ways suggested in this document to improve healthcare workers mental health in order to avoid harm to patients:

Rewards and Consequences

Employees are able to repeat behaviours that are rewarded and also able to stay away from behaviours that come with negative consequences

Adequate Work Resources

There is a strong need to always provide adequate and appropriate resources for workers to reduce their mental and physical exertion.

Adjustment in Workload

Workload management is the process of efficient workload distribution and management among staff to enhance performance. Lack of such even distribution could lead to a workload burden amongst employees leading to burnout.

Adequate Workplace Supervision

Good supervision improves relationships and productivity, while poor supervision makes way for conflicts, and lower performance levels, and results in burnout, tension, and poor workplace relationships.

Integration of Job Autonomy

Job autonomy refers to the control an employee has over how they conduct their work. This can be how they approach tasks assigned to them, set their deadlines, and have the right to choose when and where they want to work.

Job autonomy is positively associated with psychological well-being. Some of the benefits of job autonomy include:

- ❖ Reduced stress
- ❖ Increased job satisfaction
- ❖ Enhanced motivation and creativity
- ❖ Improved work-life balance

Conflict Management

Workplace conflicts can arise for various reasons, such as misunderstandings, communication breakdowns, different opinions, or competing priorities. While conflict is a natural part of human interaction, it can have significant repercussions on mental well-being if left unaddressed.

Training and Education of Healthcare Workers

Employee mental health issues can be improved if the right training is provided. To avoid adding more burden to already stressed employees, consider allocating time for them to focus solely on the training before going back to work.



CHAPTER SIX

STRATEGIC PLAN

The strategic plan covered in this document is elaborated in the tables below:

Table 1: Avoidable Harm

 Avoidable Harm				
Code	Strategic Objective	Strategy	Activities	Responsible Party
AH	AH1. Make zero avoidable harm to patients a state of mind and a rule of engagement in the planning and delivery of health care everywhere.	AH1.1. Integrate Safety into Care Quality Improvement Activities	1.Set up a national mechanism {Develop safety-focused key performance indicators (KPIs)} to coordinate, track and measure patient safety improvements	Government
			2.Coordinate and ensure alignment of patient safety programmes through regular review of safety-related incidents and near-misses, analyzing root causes, and implementing corrective actions	MDAs
		AH1.2. Foster a Culture of Safety	1. Develop and communicate a clear patient safety policy, including a non-punitive reporting system.	Health facilities
			2.Develop effective mechanisms for identifying and rewarding excellence in patient safety and quality of care	Health facilities

			3.Establish robust institutional clinical governance framework headed by the Hospital CEO (training, audits and risk management - incident reporting analysis and learning)	Government/MDAs Health facilities
			4.Support patient safety care quality activities	Professional Bodies/Associations NGOs/Partners/Community
		AH1.3. Resource Allocation for Safety	1. Provision of adequate funding and resources to ensure the delivery of qualitative and safe care	Government/MDAs Health facilities
			2. Ensure the availability of functioning equipment for safe care	Government/MDAs Health facilities
			3.Regularly assess and update healthcare infrastructure to meet safety standards	Government/MDAs Health facilities
		AH1.4. Invest in Comprehensive Training and Education	1.Provide ongoing training in patient safety principles and practices for	Government/MDAs Health facilities

			healthcare professionals	
			2.Ensure compliance with patient safety and quality of care training requirements.	Health facilities
			3. Include patient safety education in the curriculum of health institutions	Government/MDAs Health facilities
		AH1.5. Establish Clear Protocols and Guidelines	1.Develop evidence-based clinical practice guidelines incorporating safety recommendations and ensure compliance	Government/MDAs Health facilities
			2.Standardize processes and protocols for high-risk procedures	Health facilities
			3.Conduct regular audits to monitor compliance with established protocols	Government/MDAs Health facilities
		AH1.6. Implement Technology Solutions	1.Integrate electronic health record systems to enhance medication reconciliation and allergy checks	Government/MDAs Health facilities

Table 2: High-Reliability Systems

 High-Reliability Systems				
Code	Strategic Objective	Strategy	Activities	Responsible Party
HR	HR1. Build high-reliability systems to protect patients from harm	HR1.1. Implement Robust Error Reporting and Learning Systems	1. Create a non-punitive reporting culture where healthcare staff are encouraged to report safety concerns and errors	Health Facilities
			2. Develop incident reporting systems that ensure anonymity and confidentiality for reporters	Health Facilities
			3. Analyze reported incidents to identify system weaknesses and implement corrective actions	Government/MDA Health facilities
		HR1.2. Establish Standardized Systems and Protocols	1. Develop and communicate guidelines, Standard Operating Procedures, Protocols, and Standing Orders, to ensure a high reliability system.	Government/MDA Health facilities
			2. Ensure compliance with SOPs through an assurance mechanism	Health Facilities
			3. Set and enforce standards regime for certifying facilities in	Government/MDA

			line with patient safety and quality of care	
			4. Ensure respectful and dignified care of patient in line with patient safety best practices	Health Facilities
		HR1.3. Establish a Culture of Reliability	1.Promote a culture of reliability where all healthcare staff prioritizes patient safety.	Health Facilities
			2. Educate healthcare staff about the Duty of Candour, emphasizing their ethical and legal obligation to be open and honest with patients about adverse events or incidents	Government/MDA Health facilities NGOs, Professional bodies
			3.Conduct regular safety training and workshops focusing on the principles of high reliability.	Government/MDA Health facilities
			4.Encourage open communication channels for reporting safety concerns or near-misses.	Health Facilities
			5.Recognize and reward individuals and teams that demonstrate reliability in patient care	Health Facilities

			6. Encourage patients and care givers to disclose accurate information on health status to healthcare provider	Health Facilities/ Health workers
		HR1.4. Continuous Monitoring and Feedback	1. Develop feedback mechanisms for healthcare staff to report safety concerns and near-miss incidents	Health facilities
			2. Analyze data from monitoring and feedback systems to identify trends and areas for improvement	Government/MDAs
		HR1.5. Promote Interdisciplinary Collaboration	1. Multi-disciplinary and multi-professional team training/skills drills	Government/MDA Health facilities NGOs, Professional bodies
			2. Include patient safety capacity building in the training and continuous professional development programme	Government/MDA Health facilities NGOs, Professional bodies
		HR1.6. Invest in Technology and Automated Systems	1. Implement advanced healthcare technologies such as electronic health records (EHRs) and clinical decision support systems to enhance patient safety	Government/MDA Health facilities NGOs, Professional bodies

			2. Integrate barcode scanning systems for medication administration and patient identification	Health facilities
		HR1.7. Patient Safety Training and Education	1. Provide ongoing training and education for healthcare staff on high-reliability principles and practices	Government/MDA Health facilities, NGOs, Professional bodies
			2. Conduct regular safety drills and simulations to ensure staff are prepared for adverse events	Health facilities
			3. Involve patients and families in safety education to create informed partners in care	Health facilities, Health workers
			4. Provide multi-disciplinary and multi-professional team training/skills drills	Government/MDA Health facilities NGOs, Professional bodies
			5. Conduct Integrated Supportive Supervision of health care activities and procedures	Government/MDA Health facilities NGOs, Professional bodies
		HR1.8. Safety Leadership and Accountability	1. Appoint safety leaders and champions within healthcare organizations to drive safety initiatives	Health facilities
			2. Regularly assess and report on safety performance metrics to leadership and stakeholders.	Health facilities
			3. Establish clear lines of accountability for patient safety at all levels of the organization	Health facilities

Table 3: Assurance of safety of every clinical process through Infection Prevention and Control

	Assurance of safety of every clinical process through Infection Prevention and Control			
Code	Strategic Objective	Strategy	Activities	Responsible Party
IP	IP1. Assure the safety of every clinical process through Infection Prevention and Control	IP1.1. Improved infection prevention and control practices.	1. Establish an IPC Committee/Focal Person where it does not exist 2. Implement evidence-based infection prevention and control (IPC) guidelines specific to various clinical processes and settings.	Health Facility
			3. Regularly update guidelines in response to emerging infectious threats.	Government/MDAs
		IP 1.2. Education and Training in IPC	1. Train and mandate health workers to adhere to IPC protocols	Health Facility
			2. Conduct regular IPC workshops and simulations to reinforce skills	Health facilities, NGOs, Professional bodies, and Support partners
			3. Educate patients and visitors on infection prevention measures, including hand hygiene and respiratory etiquette	Health Facility/ NGOs

	Assurance of safety of every clinical process through Infection Prevention and Control			
Code	Strategic Objective	Strategy	Activities	Responsible Party
			4. Provide informational materials in waiting areas and patient rooms	Health Facility NGOs, Professional bodies
		IP 1.3. Hand Hygiene Promotion	1. Implement hand hygiene campaigns to promote and ensure proper hand hygiene practices among healthcare workers.	Health Facility NGOs, Professional bodies
			2. Provide resources for WASH (Water, Sanitation, and Hygiene), and IPC supplies including hand sanitizing stations at strategic points within healthcare facilities.	Health Facility NGOs, Professional bodies
		IP 1.4. Establish IPC as an institutional culture	1. Develop and enforce rigorous cleaning and disinfection protocols for clinical environments and equipment	Government/MDAs, Health facilities
			2. Ensure the availability of appropriate PPE and train health workers on its proper use	Government/MDAs Health Facilities



Assurance of safety of every clinical process through Infection Prevention and Control

Code	Strategic Objective	Strategy	Activities	Responsible Party
			3. Monitor the health of healthcare workers, especially during outbreaks, and provide necessary support and resources.	Government/MDAs Health Facilities
			4. Encourage vaccination campaigns among healthcare workers for vaccine-preventable diseases	Government/MDAs, NGOs Health Facilities
		IP 1.5. Community Engagement and Education	1. Engage with the community to raise awareness of infection prevention measures	Health Facilities NGOs, Professional bodies
			2. Collaborate with schools and communities to promote hygiene and vaccination	Health Facilities NGOs, Professional bodies
		IP 1.6 Audits and Quality Assurance	1. Conduct regular audits of IPC practices, compliance, processes, and outcomes.	Government/MDAs, Health facilities
			2. Implement corrective actions and improvements based on audit findings.	Health Facilities

	Assurance of safety of every clinical process through Infection Prevention and Control			
Code	Strategic Objective	Strategy	Activities	Responsible Party
		IP 1.7 Research and Innovation	1.Support research and innovation in IPC, including the development of new technologies and strategies for infection control	Health Facilities NGOs, Professional bodies
			2.Implement global best practices in IPC through research collaborations and networks	Health Facilities NGOs, Professional bodies

Table 4: Assurance of Safety of Every Clinical Process through Healthcare Waste Management

	Assurance of safety of every clinical process through healthcare waste management			
Code	Strategic Objective	Strategy	Activities	Responsible Party
WM	WM1. Assure the safety of every clinical process through appropriate healthcare	WM1.1. Implement Comprehensive Healthcare Waste Management plan	1. Develop/implement guidelines that detail safe and environmentally responsible healthcare waste management practices	Government/MDA Health facilities



Assurance of safety of every clinical process through healthcare waste management

Code	Strategic Objective	Strategy	Activities	Responsible Party
	waste management		2. Maintain comprehensive records of healthcare waste management activities, including disposal records and incident reports	Health Facilities
		WM1.2. Education and Training in Healthcare Waste Management	1. Provide training and educational programs for healthcare staff on proper waste segregation, handling, and disposal	Government, MDAs Health, Facilities. NGOs, Professional bodies
			2. Invest in research and innovation to identify more efficient and environmentally friendly waste management technologies	Government/MDAs, NGOs, Health facilities
		WM1.3. Safe Collection and Storage Protocols	1. Implement a system for healthcare facilities to segregate waste at the source into different categories (e.g., hazardous, non-hazardous, infectious).	Health Facilities
			2. Ensure the availability of designated waste storage areas with appropriate containers and labels	Health Facilities

	Assurance of safety of every clinical process through healthcare waste management			
Code	Strategic Objective	Strategy	Activities	Responsible Party
		WM1.4. Community and Public Awareness	1. Engage with the community to raise awareness of the importance of proper healthcare waste management	Health Facilities
		WM1.5. Regulatory Compliance and Reporting	1. Ensure healthcare facilities adhere to relevant waste management regulations and reporting requirements	Government/MDAs Health Facilities
		WM1.6. Continuous Monitoring and Auditing	1. Establish a system for ongoing monitoring and auditing of healthcare waste management practices	Government/MDAs Health facilities
		WM1.7. Personal Protective Equipment (PPE) Compliance	1. Ensure healthcare workers use appropriate PPE when handling and disposing of healthcare waste.	Health Facilities
			2. Conduct regular checks and provide necessary supplies to maintain PPE availability	Government/MDAs Health Facilities
		WM1.8. Collaboration with Waste	1. Collaborate with local waste management agencies and partners to ensure safe disposal	Government/MDAs, Health Facilities

Code	Strategic Objective	Strategy	Activities	Responsible Party
		Management Partners	and treatment of healthcare waste	
			2. Foster partnerships with organizations experienced in sustainable waste management	Health Facilities



Table 5: Assurance of Safety of Every Clinical Process in Maternal Care

	Assurance of safety of every clinical process in maternal care			
Code	Strategic Objective	Strategy	Activities	Responsible Party
MC	MC1. Assure the safety of every clinical process in maternal care	MC1.1. Clinical Guidelines and Protocols	1. Implement evidence based clinical guidelines for maternal care such as the Maternal Perinatal Death Surveillance Review (MPDSR)	Health Facilities
			2. Develop checklists for key maternal care processes (e.g., labor and delivery, postpartum care). Use the Maternal Early Warning Scores (M-EWS) for tracking and escalating acutely deteriorating pregnant women to safety.	Government/MD As, NGOs, Professional bodies and Health facilities
			3. Use clinical guidelines and protocols for the management of high-risk pregnancies.	Health facilities, Healthcare workers
		MC 1.2. Continuous Education and Training	1. Provide regular multi-professional training sessions and workshops for healthcare professionals on maternal care.	Government/MD As Health Facilities, NGOs, Professional bodies
			2. Provide multi-professional team training in the care of high-risk pregnancies	Government/MD As, NGO, Health Facilities
			3. Conduct skill assessments and competency checks	Health Facilities
			4. Offer certifications and continuing education credits for participation	Health Facilities, Professional bodies, NGOs
		MC1.3. Interdisciplinary Team Collaboration	1. Create interdisciplinary teams with clearly defined roles and responsibilities	Health Facilities
			2. Hold regular team meetings to discuss	Health Facilities

	Assurance of safety of every clinical process in maternal care			
Code	Strategic Objective	Strategy	Activities	Responsible Party
			patient cases and care plans.	
			3.Foster a culture of mutual respect and effective communication among team members.	Health Facilities
		MC1.4. Patient and Family Engagement	1. Ensure patients and families are informed about the care plan and any potential risks.	Health Facilities, Healthcare workers
			2. Raise community awareness on altruistic blood donation and engagement in emergency care for pregnant women	Health Facilities, Healthcare workers, NGOs
			3. Solicit feedback from patients and families to improve care processes	Health Facilities, Healthcare workers
		MC1.5. Technology Integration	1. Implement electronic health records (EHRs) to enhance information sharing	Government/MD As, Health Facilities
			2. Utilize monitoring technology for real-time patient data	Health Facilities

Table 6: Assurance of Safety in Radiology

	Assurance of safety in Radiology			
Code	Strategic Objective	Strategy	Activities	Responsible Party
RS	RS1. Assure the safety of radiologic processes	RS1.1. Radiation Safety Protocols	1. Develop and implement radiation safety protocols for all radiologic procedures.	Government/ MDAs, Health Facilities
RS	RS2. Provide adequate protection for patients to prevent radiation harms arising from diagnostic radiology, interventional radiology, nuclear medicine, and radiotherapy procedures.		2. Ensure that all healthcare professionals who perform or assist in radiologic procedures are trained in radiation safety measures	Government/MDAs, Health Facilities
			3. Use appropriate imaging protocols for different patient populations and clinical indications	Health Facilities
RS			4. Conduct pre-employment, periodic and pre-retirement examinations on professionals who work and assist in the radiology department	Health Facilities
		RS1.2. Education and Training	1. Provide adequate CPDs and training opportunities for	Health Facilities, Professional bodies

	Assurance of safety in Radiology			
Code	Strategic Objective	Strategy	Activities	Responsible Party
			professionals in radiation medicine	
			2. Provide ongoing education and training to healthcare professionals involved in radiologic procedures	Government/ MDAs
		RS 1.3 Patient education	1. Educate patients about the benefits and risks of radiologic procedures.	Health Facilities
			2. Obtain informed consent for radiologic exams, explaining the procedure and potential risks involved	Health Facilities
			3. Use appropriate signage to indicate hazardous areas and appropriate conduct within the radiology department	Health Facilities
		RS 1.4 Pregnancy screening	1. Establish procedures for screening female patients for pregnancy before performing radiologic exams, especially those that involve ionizing radiation.	Health Facilities
			2. Modify imaging protocols for pregnant patients to minimize fetal exposure	Government/MDAs, Health Facilities



Assurance of safety in Radiology

Code	Strategic Objective	Strategy	Activities	Responsible Party
		RS1.5 Incident Reporting and Analysis	1. Establish a system for reporting and investigating radiation safety incidents and near-misses.	Health Facilities
			2. Report all cases of accident or adverse events and keep appropriate records of same.	Health Facilities
			3. Conduct root cause analysis to identify the underlying causes of incidents and implement corrective actions	Health Facilities
		RS1.6 Regulatory Compliance:	1. Ensure compliance with local, state, and federal regulations related to radiation safety.	Health Facilities
			2. Stay up-to-date with evolving regulatory requirements and make necessary adjustments to practices	Healthcare workers
		RS1.7 Equipment Maintenance	1. Schedule regular maintenance and calibration of radiologic equipment to ensure accurate and safe operation.	Government, Health Facilities

	Assurance of safety in Radiology			
Code	Strategic Objective	Strategy	Activities	Responsible Party
			2. Develop a process for promptly addressing and rectifying equipment malfunctions or breakdowns	Health Facilities
			3. Ensure routine quality control checks on radiation emitting equipment to avoid leakage	Health Facilities

Table 7: Assurance of Safety of Every Clinical Process: Surgical Care Safety

	Assurance of safety of every clinical process: surgical care safety			
Code	Strategic Objective	Strategy	Activities	Responsible Party
SS	SS1 Assure the safety of every clinical process	SS1.1 Improve surgical outcomes through quality improvement processes	Clinical Process Mapping: Map out the entire surgical process to identify potential points of risk and improvement. 1. Involve key stakeholders in the mapping process, including surgeons, nurses, anesthesiologists, and other relevant staff 2. Monitor the implementation of the National Surgical Obstetric Anaesthesia and Nursing Plan (NSOANP)	Government/MDAs, and Health Facilities



Assurance of safety of every clinical process: surgical care safety

Code	Strategic Objective	Strategy	Activities	Responsible Party
			3. Establish and measure key metrics for surgical outcomes. Benchmark outcomes against standards to identify areas for improvement. 4. Regularly review and analyze data to drive quality enhancement 5. Implement the use of Pulse Oximeter as a standard of care. 6. Implement the use of Capnography as a standard of care in all patients under general anaesthesia or sedation	
			Standardized Operating Procedures (SOPs) and Preoperative Checklist Implementation: 1. Ensure use of Surgical consenting tool. (MDCN Code of Medical Ethics in Nigeria 2008) 2. Develop and implement standardized operating procedures for common surgical processes. 3. Ensure SOPs are evidence-based and regularly updated. 4. Implement preoperative checklists to enhance safety and communication among the surgical team.	Health facilities/ Healthcare workers and Lead Clinician



Assurance of safety of every clinical process: surgical care safety

Code	Strategic Objective	Strategy	Activities	Responsible Party
			5. Implement the 5 Steps to Safer Surgery. 6. Provide clinicians with guidance for peri-operative blood transfusion and antibiotics use 7. Ensure satisfactory skill mix and the availability of essential equipment for surgical and invasive procedures	
			Provide all family, social, past medical and surgical history Patient Education and Informed Consent: 1.Enhance patient education about surgical procedures and potential risks. 2.Ensure informed consent processes are thorough, and patients are well-informed about expected outcomes and potential complications. 3.Name a next of kin for best interest decisions 4. Encourage altruistic blood donation	Patient and families Health Facilities Healthcare Workers, NGOs Patient and families Patient and families



Assurance of safety of every clinical process: surgical care safety

Code	Strategic Objective	Strategy	Activities	Responsible Party
			Team Training and Communication Skills: 1. Provide training for surgical teams on effective communication and teamwork. 2. Implement tools such as Team STEPPS to enhance collaboration and reduce error 3. Provide multidisciplinary team training for members	Professional Bodies/ Associations, Health Facilities NGOs
			Create public awareness on IPC and blood donation.	NGOs/CSOs professional bodies
			Morbidity and Mortality (M&M) Conferences: 1. Conduct regular morbidity and mortality conferences to review surgical cases. 2. Analyze complications, identify root causes, and discuss strategies for improvement.	NGOs/CSOs professional bodies Health facilities
		SS1.2 Promotion of a Patient Safety Culture	1. Foster a culture of safety within the healthcare organization by encouraging reporting of errors and near-misses without fear of retribution. 2. Implement safety training programs for healthcare professionals to enhance their awareness and commitment to patient safety. 3. Establish regular forums for safety discussions and	Health care facilities

	Assurance of safety of every clinical process: surgical care safety			
Code	Strategic Objective	Strategy	Activities	Responsible Party
			sharing lessons learned from incidents.	
		SS1.3 Continuous Quality Improvement (CQI) Processes	1.Implement systematic processes for continuous quality improvement across all clinical processes. 2.Establish multidisciplinary quality improvement teams to regularly review clinical processes, identify areas for improvement, and implement changes. 3.Use data-driven approaches, including audits and outcome measurements, to monitor the effectiveness of safety interventions and drive further improvements	Health facilities, Professional organisations Government, Health facilities Government, NGOs, Health facilities

Table 8: Assurance of Safety of Every Clinical Process: Medication Safety

	Assurance of safety of every clinical process: Medication safety			
Code	Strategic Objective	Strategy	Activities	Responsible Party
MS	MS1. Assure the safety of every clinical process	MS1.1 Improve Medication safety through effective clinical governance framework.	1.Standardize medication error reporting system. 2.Collect and analyse medication error database. 3.Mandate health facilities to establish medication error reporting systems.	Government, MDAs Government, MDAs, Health Facilities Government, MDAs Health Facility

	Assurance of safety of every clinical process: Medication safety			
Code	Strategic Objective	Strategy	Activities	Responsible Party
			4. Monitor the use of appropriate devices for drug therapy (e.g., insulin).	
			Provide guidelines for prescription (and reconciliation), dispensing and administration of medicines for healthcare workers. Report all adverse drug events.	Government/MDAs Health Facility Health Facilities workers Patients and families
			Medication Reconciliation Processes: 1. Implement safe medication and standard drug prescription guidelines. 2. Implement robust medication reconciliation processes during transitions of care (admission, transfer, and discharge). 3. Utilize electronic health records to facilitate accurate and up-to-date medication lists.	Health Facilities
			Patient and Family Engagement: 1. Provide up to date medication history during each episode of care 2. Educate patients and their families about their medications and the importance of communication with healthcare providers.	Patient and families

	Assurance of safety of every clinical process: Medication safety			
Code	Strategic Objective	Strategy	Activities	Responsible Party
			3.Encourage patients to provide accurate medication histories and report any discrepancies or concerns. 4.Establish channels for patients to ask questions about their medications.	
			Healthcare Professional Education and Training: 1.Develop ongoing education and training programs for healthcare professionals on medication safety. 2.Capacity building of members on incident reporting 3.Include interdisciplinary training to enhance communication among healthcare providers 4.Train members on safe antimicrobial prescription	Professional Bodies, Health Facilities, Professional Bodies
			Implementation of Electronic Prescribing Systems: 1.Introduce or enhance electronic prescribing systems to reduce errors associated with handwritten prescriptions. 2.Ensure interoperability with other systems to facilitate seamless information exchange. 3.Provide training for healthcare professionals	

	Assurance of safety of every clinical process: Medication safety			
Code	Strategic Objective	Strategy	Activities	Responsible Party
			on the use of electronic prescribing systems.	
			Adverse Event Reporting and Analysis: 1.Establish a system for reporting adverse drug events promptly. 2.Conduct thorough root cause analyses of reported events. 3.Use the findings to implement preventive measures and share lessons learned.	

Table 9: Assurance of Safety of Every Clinical Process: Blood Transfusion Safety

	Assurance of safety of every clinical process: Blood transfusion safety			
Code	Strategic Objective	Strategy	Activities	Responsible Party
BT	BT1. Assure the safety of every clinical process	BT1.1 Improve the collection of blood and blood products BT1.2 Improve safety of collection, analysis, storage and administration of blood and blood products	1.Promote public awareness of altruistic blood donation 2.Develop and implement National standards for blood and blood products transfusion safety 3.Train all clinical staff in blood and blood products transfusion	Government, MDAs, Healthcare facilities, Healthcare workers, NGOs/CSOs Government, MDAs, Healthcare facilities Healthcare facilities Professional Bodies NGOs MDAs, Health facilities, Healthcare workers

			4.Audit of severe hazards of blood transfusion (SHOT) 5.Strengthen the National Blood Service Commission and establish a National coordinating centre for tissue and organ transplantation 6.Strengthen Medical Laboratories to meet ISO15189 (for competence and quality)	Government/MDAs
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Table 10: Assurance of Safety of Every Clinical Process: Health Care Emergency Preparedness and Management

 Assurance of Safety of Every Clinical Process: Health Care Emergency Preparedness and Management				
Code	Strategic Objective	Strategy	Activities	Responsible Party
ER	ER.1. Assure the safety of every clinical process	ER1.1. Develop and maintain a comprehensive Emergency Response Plan (ERP).	1.Conduct thorough risk assessments to identify potential threats. 2.Define clear roles and responsibilities for staff during emergencies	Government MDAs Healthcare facilities
		ER1.2 Develop and implement strategies to mitigate identified risks	1.Create and maintain a detailed ERP. 2.Regularly conduct drills and simulations to test and refine the ERP. 3.Communication Protocols	Health facilities
		ER1.3 Provide regular training and education to enhance preparedness.	1.Provide regular training programs to ensure staff are well-	Government MDAs Health facilities Partners

			prepared for emergencies. 2.Include crisis management and emergency preparedness in orientation/onboarding processes for new employees	
		ER1.4 Ensure the availability of critical resources, including medical supplies and equipment.	1.Plan for efficient resource allocation during emergencies 2.Establish effective communication protocols for timely information dissemination	Government MDAs Health facilities Partners
		ER1.5 Foster collaboration and partnerships with relevant agencies	3.Establish robust communication channels for internal and external stakeholders. 4.Develop a comprehensive communication plan to ensure timely and accurate information flow 5.Engage stakeholders in the development of the ERP process	Health facilities
		ER1.6 Establish robust traffic control system during emergency		Health facilities



Table 11: Patient and Family Engagement

	Patient and Family Engagement			
Code	Strategic Objective	Strategy	Activities	Responsible Party
PF	PF.1. Engage and empower patients and families to help and support the journey to safer healthcare	PF1.1. Engage and educate patients and patient's families, communities.	1.Promote public enlightenment (public health education)	Government/MDAs, Healthcare facilities, Healthcare workers, NGOs media, Community/Religious leaders
			2.Engage with patients, families, and relevant stakeholders (leaders of local communities, faith-based organisations, schools, NGOs, etc)	
			3.Engage with the FCCPC for the review of the Patient Bill of Rights (PBOR 2018)	
			4.Engage with communities to raise awareness on the need for a Patient Charter	
		PF1.2. Develop a Patient Charter	1.Create an enabling environment and ensure compliance: this includes, developing guidelines, ensuring compliance by healthcare facilities.	Government /MDAs
			2.Capacity development and inclusion of patient safety education in the curriculum	Government /MDAs, Communities
		PF1.3. Safety awareness raising at national and sub-national levels	1.Develop and regulate building design standards that meet safety requirements.	Government /MDAs
			2.Ensure provision of disability-friendly environment (entrance, walkways, waiting rooms, clinics and treatment area)	Government /MDAs Health Facilities, Institutions and Professional bodies
		PF1.4. Providing Safe Environment for Care	1.Ensure adequate signage and directional guides in the hospital including 'No Smoking' signs.	Government /MDAs Health Facilities

			2. Provide adequate number of PPEs and water for WASH (Water Sanitation and Hygiene).	Government /MDAs Health Facilities
			3. Use technology to receive feedback on care.	
			4. Ensure a clean, safe, and secure environment.	
			5. Ensure adequate pest control.	
			6. Prompt incident investigation and disclosure of findings to patient/family. (<i>'Duty of candour' process</i>)	
			7. Provide psychological and other support in the aftermath of a serious patient safety incident to patients, family, and staff.	
			8. Create organisational culture and frameworks: for effective health care worker-patient communication and reporting e.g., suggestion box, toll-free lines, and setting up a patient safety desk in the facility.	
			9. Integrate feedback from patient experiences into the institutional continuous quality improvement process.	
			10. Follow professional standards and hospital guidelines for safe use of hospital equipment.	
			11. Ensure that excellent interpersonal communication is maintained between patient/family and healthcare workers.	
			12. Ensure that patients' ill health and care options are explained in simple language.	
			13. Encourage patient and patient's family members on their duty to speak up or to make inquiries on issues of concern	
			14. Patient and family members should disclose their health risk exposures and experiences freely	
			15. Comply with safety protocols at health facilities.	

Table 12: Health Worker Education, Skills and Safety

	Health Worker Education, Skills and Safety			
Code	Strategic Objective	Strategy	Activities	Responsible Party
HW	HW.1. Health Worker Education, Skills and Safety.	HW1.1 Improve learning and knowledge on patient safety and quality of care.	1.Integrate patient safety and quality of care education into the curriculum of all health-related courses in institutions of learning. 2. Mandate inclusion of patient safety and quality of care in CPD programmes.	Government/N GOs/Health facilities/ institutions and professional bodies.
			3.Participate in patient safety and quality of care education programmes available in their health facilities and elsewhere. 4. Comply with patient safety and care quality essential training requirements.	Health Workers
			5.Provide feedback on quality of care received.	Government /MDAs/Patient and Patient Family, Health facility

Table 13: Health Worker Protection and Safety

	Health Worker Protection and Safety			
Code	Strategic Objective	Strategy	Activities	Responsible Person
HW	HW.2. Healthcare	HW.2.1 Improve health worker	1.Provide adequate funding for the health system supply chain	Government/MDAS/ Healthcare facilities



Health Worker Protection and Safety

Code	Strategic Objective	Strategy	Activities	Responsible Person
	Worker Protection and Safety	safety through the provision of adequate resources.	2.Ensure availability of vaccines and vaccination for healthcare workers. 3.Develop and strengthen policies for safe working conditions in the health sector. 4.Inspect and monitor for safe work environment. 5.Develop a compensation policy for healthcare workers who fall victim to occupational hazards that lead to incapacitation or death. 6.Ensure availability of equipment and supplies to support a safe work environment at the healthcare facilities	Government/MDAS/ Healthcare facilities Government/MDAS/ Government/MDAs, health facilities Government/MDAs/ Healthcare facilities
			7.Comply with the safe use of sharp boxes and PPEs. 8.Comply with occupational health requirements for vaccinations.	Health workers Health workers



Health Worker Protection and Safety

Code	Strategic Objective	Strategy	Activities	Responsible Person
			9. Use PPEs in health facilities as appropriate.	Patient/ Patient Family, Health workers
			10. Train members in the appropriate use of safe work practices	Professional bodies/associations
			11. Advocate for safe work environment for healthcare workers.	Professional bodies/associations
			12. Organize workplace safety training for healthcare workers (multi-professional)	Health facilities
			13. Educate their members on post-exposure prophylaxis or protocols	Professional bodies and associations
		HW2.2 Protect Healthcare Workers Mental Health and Wellbeing	14. Include employees' mental health and wellbeing in existing governing policy	Government/MDAS/ Healthcare facilities
			15. Create a reward and consequence management system	Healthcare facilities
			16. Provide adequate resources for employees to work	Healthcare facilities
			17. Make adjustment in employees' workload	Healthcare facilities
			18. Promote an effective workplace supervision.	Healthcare facilities
			19. Integrate a job autonomy practice	Healthcare facilities

	Health Worker Protection and Safety			
Code	Strategic Objective	Strategy	Activities	Responsible Person
			20. Institute a healthy conflict management system 21. Train and educate healthcare workers on mental health conditions	Healthcare facilities Healthcare facilities

Table 14: Knowledge Management and Learning in Patient Safety

	Knowledge Management and Learning in Patient Safety			
Code	Strategic Objective	Strategy	Activities	Responsible Party
KM	KM.1. Knowledge Management and Learning in Patient Safety	KM.1.1. Improving knowledge management and learning in patient safety and quality of care for health workers.	1. Establish and implement robust clinical governance system for health services. 2. Coordinate existing databases on patient safety and health quality.	Government/MDAs
			3. Institute and sustain incident reporting system and analyse incidents for learning.	Healthcare facilities
			4. Train Healthcare Workers on Clinical Governance	Healthcare workers

	Knowledge Management and Learning in Patient Safety			
Code	Strategic Objective	Strategy	Activities	Responsible Party
			5. Provide feedback to support institutions towards improving patient safety and quality of care	Patient/patient families, Healthcare workers
			6. Encourage members to access repositories (library) on patient safety and quality of care information.	Professional bodies / associations
			7. Advocate and support effective information sharing amongst stakeholders	CSO / communities

Table 15: Synergy, Partnership and Financing

	Synergy, Partnership and Financing			
Code	Strategic Objective	Strategy	Activities	Responsible Party
SP	SP.1. Synergy/Partnership /solidarity	SP1.1 Develop and sustain multisectoral and multinational synergy, partnership and solidarity to improve patient safety and quality of care.	1. Advocacy visits to relevant stakeholders 2. Establish national and sub-national fora of stakeholders. 3. Ensure that the annual Patient Safety Day is observed with adequate representation of all stakeholders. 4. Facilitate periodic meetings of stakeholders for updates on care quality and patient safety programmes.	Government / MDAs
			5. Partner with local community and CSOs. 6. Institutionalize mechanisms for feedback on issues and complaints relating to patients' and stakeholders' engagements. 7. Promote inter-professional training and practice (teamwork).	Healthcare facilities

	Synergy, Partnership and Financing			
Code	Strategic Objective	Strategy	Activities	Responsible Party
			8.Engage with the clinical governance program of the health care facility.	Healthcare workers, Patients/families
			9.Educate patients and patients' families to encourage active participation in patient safety processes.	Healthcare facilities
			11.Establish patient and family liaison team	
			12.Continue medical education of members to include respectful communications and cultural awareness.	Professional bodies / associations
			13.Create and develop content to promote the importance of synergy and partnership in patient safety for patients, families, partners and community.	
			14.Promote messages of partnership and unity on patient safety and quality of care.	CSO / communities
			15.Elevate the voice of patients about their experience on healthcare.	
			16.Support community meetings on patient safety with stakeholders	
			17.Develop annual budget on patient safety and care quality.	Government/MD As Health facilities
	SP.2. Funding/Financing	SP.2.1 Prioritization, Mobilization and Resource Allocation of	18.Mobilize resources for patient safety and care quality	
			19.Map and engage Stakeholder (one one meetings and round table discussion etc)	
			20.Integrate patient safety and care quality into annual operation plan (AOP)	

	Synergy, Partnership and Financing			
Code	Strategic Objective	Strategy	Activities	Responsible Party
		funds for patient safety.	21. Develop a plan of action on quality of care and patient safety.	Healthcare facilities
			22. Train health workers on health financing.	Government/MD As/Health facilities
			23. Promote enrollment into Health Insurance Schemes	
			24. Support projects for improving patient access to healthcare	CSO / communities



CHAPTER SEVEN

MONITORING AND EVALUATION FRAMEWORK

7.0 Goal of the Monitoring and Evaluation Framework

The goal of the monitoring and evaluation framework is to assure patient safety, and achieve zero avoidable harm in healthcare. A structured approach is required in developing a comprehensive monitoring and evaluation framework for patient safety to achieve the goal of zero avoidable harm in healthcare. The framework includes key indicators, methods of data collection, analysis processes, and mechanisms for continuous improvement. By implementing this monitoring and evaluation framework, healthcare organizations can systematically assess their patient safety performance, identify areas for improvement, and work towards the strategic goal of achieving zero avoidable harm in healthcare (clinical governance).

7.1 Key Components of the Monitoring and Evaluation Framework

7.1.1 Key Performance Indicators

Incidence of Adverse Events:

- ❖ Track the number of adverse events, near misses, and sentinel events.
- ❖ Stratify incidents by severity and type.

Compliance with clinical guidelines and Protocols:

- ❖ Monitor adherence to evidence-based clinical guidelines and patient safety protocols.
- ❖ Focus on high-risk areas such as surgery, medication administration, and infection control.
- ❖ Medication Error rates
- ❖ Health Care Associated Infection Rates

Patient Safety Culture Surveys:

- ❖ Conduct regular surveys to assess the perception of patient safety among healthcare staff.
- ❖ Use validated tools to measure safety culture and identify areas for improvement.

Readmission Rates:

- ❖ Monitor rates of unplanned hospital readmissions.
- ❖ Surgical complication rate
- ❖ Analyze reasons for readmissions to identify potential safety concerns.

Funding/Financing

- ❖ Number of states and facilities that have patient safety in their budget

7.1.2 Data Collection Methods:

Incident Reporting Systems:

- ❖ Establish a robust system for reporting adverse events and near misses.
- ❖ Ensure a culture that encourages reporting without fear of reprisal.
- ❖ Conduct regular clinical audits to assess compliance with safety protocols.
- ❖ Include audits of medical records, medication administration, and infection control practices.

Patient Interviews and Surveys:

- ❖ Collect feedback directly from patients regarding their perceptions of safety.
- ❖ Use patient interviews and surveys to identify areas for improvement.

Review of Root Cause Analyses (RCAs):

- ❖ Review findings from RCAs for serious incidents.
- ❖ Analyze common themes and contributory factors to inform preventative strategies

7.1.3 Analysis and Reporting:**Regular Data Analysis:**

- ❖ Analyze incident data regularly to identify trends and patterns.
- ❖ Use statistical methods to assess the significance of changes over time.

Quarterly and Annual Reports:

- ❖ Generate comprehensive reports on patient safety performance.
- ❖ Include a summary of incidents, actions taken, and progress toward zero avoidable harm.

Benchmarking:

- ❖ Compare patient safety performance against industry benchmarks and best practices.
- ❖ Identify leading indicators and learn from high-performing organizations.

7.1.4 Continuous Improvement Mechanisms:**Feedback Loops:**

- ❖ Establish mechanisms for providing feedback to healthcare teams and individuals.
- ❖ Encourage learning from incidents and implementing changes.

Quality Improvement Initiatives:

- ❖ Develop and implement targeted improvement projects based on identified safety gaps.
- ❖ Monitor the effectiveness of interventions through PDSA (Plan-Do-Study-Act) cycles.

Training and Education Programs:

- ❖ Offer ongoing training programs to address identified skill gaps.
- ❖ Ensure that staff is continually educated on the latest safety practices.

7.1.5 Responsibilities and Accountability:

The responsibility for the various activities in the implementation strategy plan should be clearly defined by the health facility. In addition, there should be clearly defined roles and responsibilities for monitoring and evaluation within the healthcare organization. Accountability for implementing improvement initiatives based on evaluation outcomes should be clearly assigned.

7.1.6 Review and Adaptation:

- ❖ Conduct periodic reviews of the monitoring and evaluation framework to ensure relevance and effectiveness.
- ❖ Adapt the framework based on changes in healthcare practices, technology, and regulatory requirements.

7.2 Monitoring and Routine Data Collection

Monitoring and routine data collection serve as the vigilant guardians of healthcare systems, ensuring that the provision of care aligns with the highest standards, and continuously striving for improvement. In this policy and implementation document, monitoring and routine data collection embody a commitment to excellence, patient-centered care, and the relentless pursuit of a healthcare system that not only meets global standards but continually evolves to exceed them.

7.2.1 Purpose

The primary purpose of monitoring and routine data collection is to systematically assess and enhance patient safety, care quality, and overall healthcare efficacy. By adopting a structured approach to gather and analyze data, healthcare organizations gain valuable insights into their performance, enabling them to identify areas for improvement and address challenges proactively. This systematic scrutiny allows for the early detection of potential issues, fostering a culture of continuous learning and improvement.

7.2.2 Benefits

1. Assurance of Patient Safety:

- ❖ Timely identification and mitigation of adverse events, near misses, and sentinel events.
- ❖ Stratification of incidents by severity and type for targeted interventions.
- ❖ Promotion of compliance with evidence-based clinical guidelines and safety protocols.

2. Enhanced Quality of Care:

- ❖ Monitoring and adherence to high-quality standards in critical areas such as surgery, medication administration, and infection control.
- ❖ Reduction of medication errors and health care-associated infections through targeted interventions.
- ❖ Improvement of patient safety culture through regular surveys and feedback mechanisms.

3. Informed Decision-Making:

- ❖ Regular data analysis to identify trends, patterns, and areas for improvement.
- ❖ Generation of comprehensive reports, facilitating informed decision-making by healthcare leadership.
- ❖ Benchmarking against industry standards to identify leading indicators and adopt best practices.

4. Continuous Improvement:

- ❖ Establishment of feedback loops for continuous learning and implementation of changes.
- ❖ Implementation of targeted improvement projects based on identified safety gaps.
- ❖ Ongoing training programs to address skill gaps and ensure staff is updated on the latest safety practices.

5. Accountability and Responsibility:

- ❖ Clearly defined roles and responsibilities within the healthcare organization.
- ❖ Accountability for implementing improvement initiatives based on evaluation outcomes.
- ❖ Periodic reviews and adaptation of the monitoring framework to ensure relevance and effectiveness.

6. Financing

- ❖ Including patient safety in Annual operation plan
- ❖ Resource mobilization (Government and Partners)

Table 16: Monitoring Framework for Routine Data Collection

Key Performance Indicator (KPI)	Data Source	Frequency of Data Collection	Person Responsible	Target/Threshold	Data Collection Tools
Incidence of Adverse Events	Incident Reporting System	Continuous	Patient Safety Officer	Zero avoidable harm	Incident reporting forms
Compliance with Clinical Guidelines and Protocols	Clinical Audits	Quarterly	Quality Assurance Team	Adherence to guidelines	Audit checklists
Medication Error Rates	Incident Reporting System, Medication Records	Monthly	Pharmacy Department	Minimal errors	Medication error logs
Healthcare Associated Infection Rates	Infection Control Records	Monthly	Infection Prevention Team	Low infection rates	Infection control reports
Patient Safety Culture Surveys	Surveys and Validated Tools	Bi-annual	Patient Safety Officer	Positive safety culture	Safety culture survey forms
Readmission Rates	Patient Records	Monthly	Quality Improvement Team	Reduced readmissions	Readmission reports
Surgical Complication Rate	Surgical Records	Quarterly	Surgical Department	Low complication rates	Surgical
		Bi annually			
Emergency Response and Risk management preparedness	Clinical Audit/incident reports		Patient safety/Clinical Governance team	100% of target drills and availability of essential resources during drills	Audit checklist/incident logs
Proportion of state and health facilities that have patient safety in their Budget	Government annual budget	Annually	Patient Safety Officer	Zero avoidable harm	Audit checklists

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