

FACILITATOR MANUAL

Healthcare Quality and Patient Safety in Primary Healthcare Settings



HUMAN CAPITAL INVESTMENT PROJECT
KHYBER PAKHTUNKHWA

Activity: Healthcare Quality & Patient Safety in Primary Healthcare Settings

Project Name: Khyber Pakhtunkhwa Human Capital Investment Project
(KP-HCIP)

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Map of Khyber Pakhtunkhwa

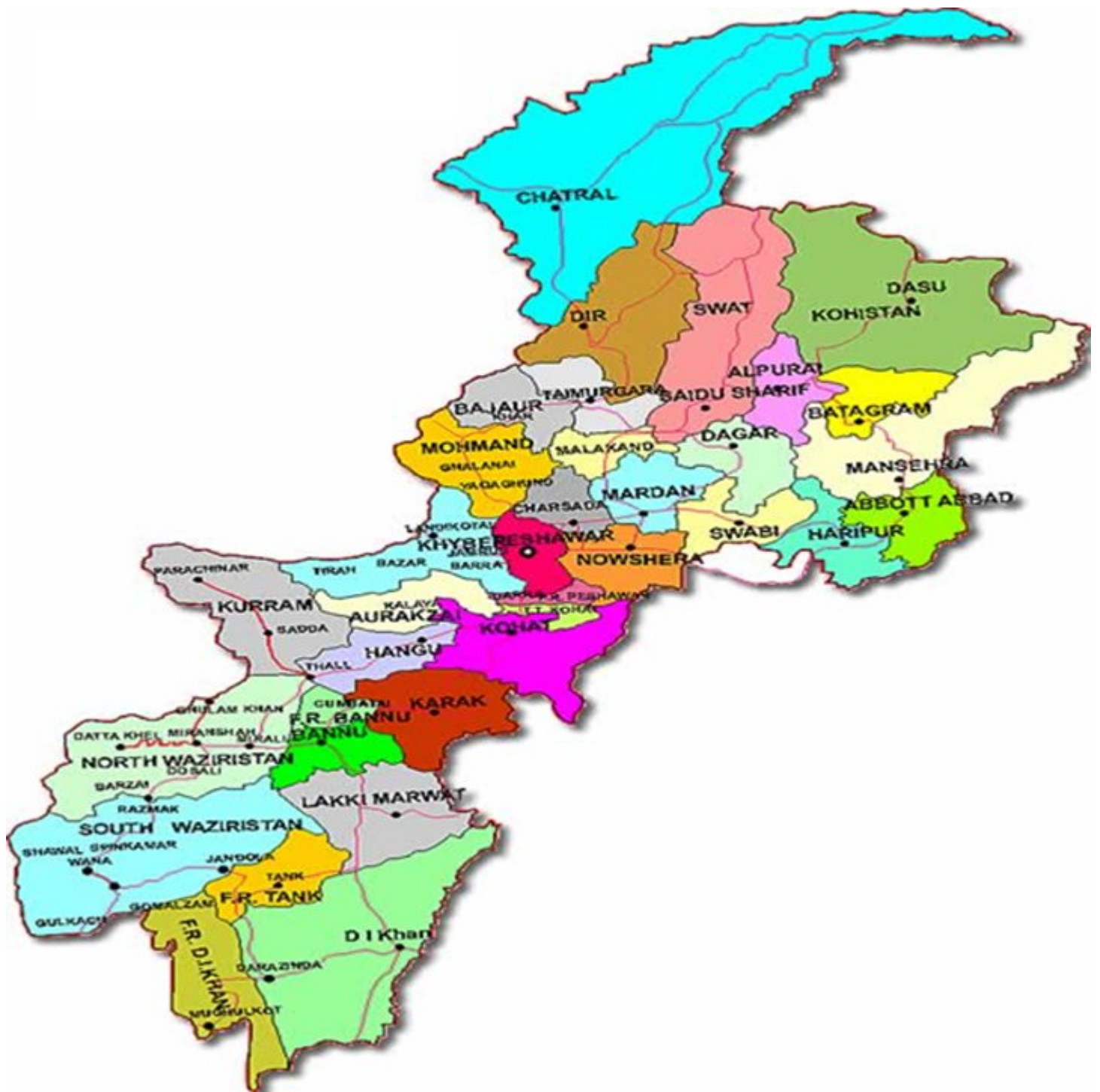


Table of Contents:

<u>CONTENT</u>	<u>PAGE No</u>
CHAPTER ONE:	01
Introduction to Healthcare Quality and Patient Safety	
CHAPTER TWO:	10
Common Patient Safety Risks in Primary Healthcare and Their Management	
CHAPTER THREE:	26
Developing Patient Safety Culture and Communication	
CHAPTER FOUR:	39
Challenges and Solutions in Implementing Quality and Safety	
CHAPTER FIVE:	48
Ethical Considerations in Patient Safety	

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and healthcare professionals who contributed their valuable insights and expertise throughout the development process. Their unwavering support and commitment to improving patient safety and healthcare standards have been instrumental in shaping this manual.

Special thanks are also due to the primary healthcare teams, hospital managers and frontline healthcare workers whose continuous efforts to ensure safe, equitable and high-quality care served as the foundation for this initiative.

This manual is intended to serve as a practical resource for healthcare providers at all levels, fostering a culture of safety, accountability and continuous improvement across Khyber Pakhtunkhwa's health system. Through this shared effort, we aspire to enhance healthcare delivery, safeguard patient well-being and contribute to the broader goal of building a healthier and more resilient province.

Introduction to the Manual

TRAINING MATERIAL:

- Trainers Manual: A detailed guide (hard and soft copies) as how to conduct each session along with necessary training material will be provided to each facilitator.
- Participants Manual: This booklet will be provided to each participant (both hard and soft copies) containing all the necessary information for future reference.

How to Use this manual?

This This training manual is designed to enhance the understanding and practical application of healthcare quality and patient safety principles among healthcare professionals. It aims to build a culture of safety and continuous quality improvement within health facilities in Khyber Pakhtunkhwa.

This manual serves as a reference and training guide for healthcare trainers, supervisors and frontline workers working in primary healthcare settings. Participants are encouraged to use the manual actively—through discussions and group exercises.

The Objectives of the Health Care Quality & Patient Safety Training are:

1. Strengthen Knowledge of Healthcare Quality Concepts

Equip healthcare providers with a comprehensive understanding of the core dimensions of healthcare quality, including safety, effectiveness, efficiency, equity, timeliness and patient-centeredness. Enhance their capacity to apply these principles in daily clinical and administrative practice.

2. Promote a Culture of Patient Safety

Train healthcare workers to recognize, report and prevent medical errors and adverse events by fostering a culture of transparency, teamwork and accountability. Emphasize the importance of non-punitive learning systems to improve safety outcomes and reduce preventable harm.

3. Enhance Clinical Governance and Quality Improvement Practices

Provide participants with practical tools and methods for continuous quality improvement (CQI), including root cause analysis, clinical audits and use of performance indicators. Strengthen their ability to lead and sustain quality initiatives within their respective health facilities.

4. Improve Communication and Patient Engagement

Empower healthcare workers to strengthen communication with patients, families and multidisciplinary teams. Promote shared decision-making, informed consent and respectful care as vital components of patient safety and quality service delivery.

5. Strengthen Health System Support and Accountability

Develop participants' understanding of how organizational structures, leadership and data-driven decision-making contribute to healthcare quality improvement. Emphasize community engagement, monitoring and reporting mechanisms to ensure accountability and sustainability of quality and safety practices.

Potential Workshop Participants include:

- ✓ Primary Healthcare Workers including Medical Officer, Medical Technician, Lady Health Visitor & Lady Health Supervisors
- ✓ Program Managers of district and provincial health departments
- ✓ Organizations working in Primary Healthcare Settings

Expected Outcomes

Participants will possess a comprehensive understanding of the core principles of healthcare quality and patient safety. They will be equipped to identify and address factors that influence the quality of care, including clinical effectiveness, patient-centeredness, efficiency, equity and timeliness. Through this training, healthcare workers will gain the knowledge and practical skills needed to minimize risks, prevent medical errors and ensure safe, effective and respectful care delivery across all healthcare settings.

Furthermore, participants will strengthen their communication and teamwork competencies, enabling them to engage effectively with colleagues, patients and families. By the end of the training, healthcare workers will be able to implement quality and safety standards, promoting a culture of error reporting and leading local initiatives to improve healthcare outcomes. Ultimately, the training aims to produce a skilled workforce capable of quality improvement, reducing preventable harm and enhancing patient trust and satisfaction within the healthcare system.

Training Agenda

Complete details for each block and its sub sessions with information about methodology, different interactive activities and resource materials required are listed in detail. In this manual, Participatory techniques are adapted to make learning as hands-on as possible. The training agenda has been made flexible for the trainers. The training agenda is set for 2 days for healthcare providers working in primary settings including BHUs, RHCs, Civil Dispensaries, Category-C and Category-D hospitals.

A. Facilitation Methods

Trainers should apply adult learning principles while considering the participants' varying levels of experience in the healthcare delivery system. An effective trainer will leverage the skills and personalities within the group to create an engaging and productive workshop. The following participatory training methods can be beneficial:

i. Power Point Presentation

Often referred to as the "lecture method," this approach has faced criticism for being facilitator-centered and making participants passive listeners. However, it can be effective, particularly when introducing new or unfamiliar topics. The facilitator should present information in a way that encourages group interaction, promoting an interactive learning environment. To enhance presentations, the facilitator can use anecdotes, humor, handouts, PowerPoint slides, audio-visual materials and ask questions to engage participants.

ii. Brainstorming

Brainstorming encourages quick, collaborative discussions on a topic, fostering creativity and generating ideas swiftly. It's particularly useful for building consensus around contentious issues, with points raised during the session often recorded on a flip chart.

iii. Real Life Experience Sharing

This method allows selected participants or guest speakers to share relevant life experiences that connect to the topics being discussed, adding a personal touch to the content. It's important to ensure that speakers stay on topic and adhere to their allotted time.

iv. Small Group Discussion

The primary goal of small group discussions is to maximize participation and foster new insights among participants. Groups of four or five are ideal, as they allow for more personal interaction, reduce intimidation and encourage idea exchange. Considerations for group work include the topic, objectives, assigned tasks, desired participation level, available resources, time management, group composition (including gender) and seating arrangements. Each group should have a chairperson and a note-taker, with key points recorded on a flip chart for reporting back to the larger group. The facilitator should then synthesize and clarify any emerging issues.

v. Case Study

In this method, participants analyze a real or fictional case in small groups before discussing it with the larger group. The facilitator presents the case details and invites participants to propose solutions and share their opinions without dictating the best answer or critiquing contributions.

B. Logistic Support:

Training arrangements should be made well in advance and all necessary equipment and supplies should be arranged. Required training equipment include:

- Laptop, projector & un-interrupted power supply
- Flip Flowcharts with Stand
- Colored Markers, Sticky Notes
- Necessary Stationary Required for participants (Writing pad, pen, pencil etc)
- Required No. of pre-test and post-test questionnaires copies
- Required No. of participants handouts

C. Preparatory Checklist for the trainer

The trainer should:

- Thoroughly understand the training manual's content.
- Review the training objectives, session outlines and activities for each session, including learning goals, time, resources and trainer instructions as detailed in the manual.
- Familiarize themselves with the session slides, particularly those with presentations.
- Review the pre/post-test and course evaluation forms and prepare copies for all participants.
- Make copies of handouts, role-play scenarios and checklists to ensure all audio-visual equipment is functional.
- Check the training venue, including seating arrangements, lighting and fans or air conditioning (for summer).

Create flip flowcharts as needed for the sessions and write the daily agenda on them

Chapter One

Introduction to Healthcare Quality and Patient Safety



Introduction to Healthcare Quality and Patient Safety

Session Overview

This session introduces participants to the fundamental concepts of healthcare quality and patient safety within the context of primary healthcare in Khyber Pakhtunkhwa (KP). It aims to help primary healthcare workers understand why quality and safety are essential, how they relate to patient outcomes and what principles and systems support them in practice.

The facilitator will guide participants through an interactive learning experience combining short presentations, brainstorming and small group work.

Learning Objectives

By the end of this session, participants will be able to:

1. Explain the meaning and importance of healthcare quality and patient safety.
2. Identify the six WHO dimensions of quality care — safe, effective, patient-centered, timely, efficient and equitable.
3. Describe the link between quality of care and health outcomes.
4. Recognize key concepts in patient safety and common factors leading to patient harm.
5. Reflect on practical ways to improve safety and quality within their own facilities.

Session Outline and Time Allocation

Activity	Methodology	Facilitator Role
Introduction and Icebreaker	Interactive discussion	Welcome participants and introduce the topic
Brainstorming Activity: “What Does Quality Mean to You?”	Group brainstorming	Engage participants to elicit their perceptions
Mini Lecture: Key Concepts of Quality & Safety	Presentation + Q&A	Present slides, explain examples from local context
Group Work: “Spot the Risk”	Case study group work	Facilitate analysis and discussion
Discussion: Link Between Quality and Health Outcomes	Whole group reflection	Summarize participants’ insights
Wrap-up and Key Takeaways	Summary + feedback	Reinforce key messages and close session

Facilitator Notes

1. Opening the Session

Purpose: To welcome participants and create an engaging learning environment.

Facilitator Instructions:

- Greet participants warmly and introduce yourself.
- Briefly explain the purpose of this training manual and how it fits into improving primary healthcare services under the KP-HCIP.

Ask:

“When you hear the words ‘*quality healthcare*’ — what comes to your mind?”
“Have you ever seen a situation where poor quality or unsafe care affected a patient’s outcome?”

- Note key words on a flip chart (e.g., *trust, safety, efficiency, timely service, teamwork*).
- Conclude by saying:

“Today’s session will help us understand these concepts more deeply and explore how we can ensure safety and quality in every patient interaction.”

2. Brainstorming Activity – “What Does Quality Mean to You?”

Objective: To activate prior knowledge and set the context for learning.

Instructions:

1. Divide participants into small groups of 4–6.
2. Ask each group to write **three words or short phrases** that describe *quality in healthcare*.
3. After 5 minutes, have each group share their answers.
4. Cluster similar ideas on the board under themes (e.g., *timely care, safety, equity, patient respect*).
5. Transition to the formal definition by saying:

“Your ideas closely reflect the WHO’s six dimensions of quality — safe, effective, patient-centered, timely, efficient and equitable.”

Facilitator Tip:

Encourage all voices. Avoid correcting participants during brainstorming — focus on gathering ideas.

3. Presentation: Key Concepts of Healthcare Quality and Safety

Purpose: To introduce structured knowledge aligned with the participant manual.

Key Discussion Points (with slide references):

- **Definition of Quality Healthcare** (National Academy of Medicine)

- **Importance of Quality in Primary Healthcare** — link to patient trust, cost-effectiveness and health equity.
- **Six WHO Dimensions of Quality Care** — explain each with examples from local primary healthcare centers.
- **National Health Policy on Quality in Pakistan** — highlight leadership, capacity building and continuous improvement.
- **Principles of Patient Safety** — “First, do no harm.”
- **Global Patient Safety Facts** (e.g., 1 in 10 patients harmed; 50% preventable).

Facilitator Notes:

- Use real examples (e.g., a vaccination delay, medication mix-up or infection control lapse).
- Pause after each key concept and invite one or two reflections.
- Reinforce that *quality and safety are shared responsibilities*, not just management’s duty.

4. Group Work Activity – “Spot the Risk!”

Objective: To apply understanding of safety principles to real-world clinical scenarios.

Instructions:

1. Divide participants into four groups.
2. Provide each group with **one short case scenario**:
 - **Medication Error:** Nurse gives wrong dosage due to poor labeling.
 - **Infection Control:** Reuse of syringes between patients.
 - **Surgical Safety:** Missing instrument count leads to retained item.
 - **Diagnostic Error:** Delay in lab result causes treatment delay.
3. Ask each group to:
 - Identify what went wrong.
 - Suggest how it could have been prevented.
 - Share one key lesson for all staff.
4. Allow sufficient time for group discussion and for presentation.

5. Discussion – Linking Quality to Health Outcomes

Objective: To consolidate learning and emphasize practical application.

Facilitator Prompts:

- “How does improving quality and safety affect the health of your patients?”
- “What small actions can you take in your own facility to improve safety today?”
Encourage concrete examples such as proper hand hygiene, ensuring patient identification, or safe medication practices.
- Encourage teams to identify *system failures*, not just individual errors.
- Summarize each scenario with a teaching point (e.g., need for double-check systems, infection control protocols, communication).

Key Takeaways

- Quality healthcare = care that is safe, effective, patient-centered, timely, efficient and equitable.
- Patient safety is everyone’s responsibility.
- Errors often result from system failures, not bad people.
- Continuous improvement and open reporting lead to safer care.

Facilitator Tips

- **Time management:** Keep each section within its time limit; avoid overlong discussions.
- **Encourage sharing:** Validate participant experiences; link back to principles.
- **Refer to manual:** Direct participants to the relevant manual section (e.g., 1.3 Principles of Healthcare Quality).
- **Engage all participants:** Mix question styles — factual (“What are the six dimensions?”) and reflective (“Why is patient trust important?”).
- **Connect theory to practice:** Use examples from local healthcare facilities to make learning relevant.

Session Power Point Presentation Slides

Introduction to Healthcare Quality and Patient Safety



Khyber Pakhtunkhwa Human Capital Investment Project (KP-HCIP)

1

Session Objectives

By the end of this session, participants will be able to:

1. **Define** healthcare quality and patient safety.
2. **Explain** the importance of quality in primary healthcare.
3. **Identify** principles and standards of quality healthcare.
4. **Understand** the link between quality care and health outcomes.
5. **Describe** key patient safety concepts and causes of patient harm.

2

“What Does Quality Mean to You?”

Introduction to Healthcare Quality and Patient Safety

- ✓Quality and safety are the **core of effective healthcare**.
- ✓Primary care is where most patient interactions happen.
- ✓Quality = treating illness **and** preventing harm.
- ✓Patient safety = preventing avoidable harm.
- ✓Strengthening these ensures **trust, better outcomes, and UHC**.

WHO's Six Dimensions of Healthcare Quality



5

Why Quality Matters in Primary Healthcare

- Improves **health outcomes**.
- Builds patient **trust and satisfaction**.
- Promotes **universal health coverage**.
- Is **cost-effective** and prevents hospitalizations.
- Reduces **health disparities**.
- Strengthens **community health**.

6

Key Factors for Improving Quality

The WHO Health System Framework

System Building Blocks



ACCESS
COVERAGE

QUALITY
SAFETY

Overall Goals / Outcomes



7

National Health Policy on Quality

- Framework for improving healthcare services across Pakistan.
- Vision: Safe, effective, patient-centered, timely, efficient, equitable care.
- Aligned with global best practices and UHC goals.

8

Key Components of the Policy

- **Vision and Goals** – set direction for quality care.
- **Strategic Priorities**: safety, effectiveness, patient-centered care.
- **Implementation Framework**: leadership, training, M&E.
- **Stakeholder Engagement**: collaboration across levels.
- **Continuous Improvement**: learning and adapting.

9

Benefits of a National Quality Policy

- Improved **patient outcomes**.
- Increased **patient satisfaction**.
- **Cost savings** and efficiency.
- Stronger **accountability and trust** in the system.

10

Linking Quality and Health Outcomes

- Quality = better survival, faster recovery, fewer complications.
- Ensures **patient safety** and reduces medical errors.
- Builds **patient engagement** and compliance.
- Promotes **equity** and long-term population health.

11

Introduction to Patient Safety

- Defined as: *"The absence of preventable harm to a patient..."*
- Based on the principle: **"First, do no harm."**
- Unsafe care causes **millions of preventable deaths** annually.



12

Key Global Facts

- ✓ 1 in 10 patients harmed in healthcare.
- ✓ 4 in 100 people in LMICs die from unsafe care.
- ✓ 50% of harm is preventable — half due to **medication errors**.
- ✓ 40% of patients harmed in primary/ambulatory settings.
- ✓ Unsafe care costs **trillions globally** each year.

13

Key Concepts in Patient Safety

- **Adverse Events** – harm from medical care.
- **Near Misses** – potential harm avoided.
- **Medication Safety** – correct prescribing, dispensing, administering.
- **Surgical Safety** – adherence to checklists.
- **Infection Control** – prevent HAIs.
- **Patient Identification** – correct patient, correct procedure.

14

Promoting a Culture of Safety

- Leadership commitment to safety.
- Teamwork and communication.
- Transparency and accountability.
- Learning from errors, not blaming.
- Continuous improvement based on data.

15

Factors Leading to Patient Harm

- **System & organizational factors:** workflow gaps, low staffing.
- **Technological factors:** system errors, misuse of tech.
- **Human factors:** fatigue, communication failure.
- **Patient factors:** low health literacy.
- **External factors:** policy gaps, funding constraints.

16

The Swiss Cheese Model

- Each “slice” = a layer of defense (protocols, training, policies).
- “Holes” = weaknesses or gaps.
- Harm occurs when **holes align**, allowing an error to pass through.



17

Group Activity

“When Things Go Wrong”

18

Chapter 2

Common Patient Safety Risks in Primary Healthcare and Their Management



Common Patient Safety Risks in Primary Healthcare and Their Management

Session Overview

This session equips primary healthcare workers to identify, prevent and manage common patient safety risks in their daily practice. By working through real-life scenarios and engaging in group activities, participants will develop a deeper understanding of how simple, consistent actions can prevent harm to patients and healthcare workers.

Learning Objectives

By the end of the 3-hour session, participants will be able to:

1. Identify at least five common patient safety risks in primary healthcare.
2. Describe the causes and prevention strategies for:
 - Medication errors
 - Healthcare-associated infections (HAIs)
 - Diagnostic errors
 - Unsafe injection practices
 - Sepsis
 - Surgical errors (in minor procedures)
3. Apply safety principles to real-world clinical situations.
4. Demonstrate teamwork, communication and accountability in promoting patient safety.

Facilitator Preparation

Before the session:

- Review Chapter 2 of the participant manual to ensure content familiarity.
- Print enough copies of **case scenarios** (one per group).
- Prepare flip-chart pages in advance with headings such as:
 - “Common Patient Safety Risks”
 - “How Errors Happen”
 - “Our Safety Commitments”
- Keep all materials organized (markers, sticky notes, pens).

Session Breakdown

Component	Method
Introduction and Icebreaker	Plenary
Mini-Lecture: Common Safety Risks	Interactive lecture
Group Activity: Case Scenarios	Small-group work
Group Presentations & Debrief	Discussion
Summary & Reflection	Plenary reflection

Facilitation Steps

Step 1: Introduction

Objective: Create engagement and highlight why patient safety matters in primary healthcare.

“Welcome everyone. We’ll be exploring one of the most important aspects of quality healthcare — *patient safety*. Many of the safety incidents that cause harm are preventable and occur in places just like ours — in primary care clinics and community health centers.”

1. Ask participants:

“Can you think of a time when a small mistake almost caused or did cause harm to a patient?”

2. Let 3–4 participants share short examples (1 minute each).
3. Record their examples on a flip chart titled ‘**What Can Go Wrong?**’
4. Conclude with:

“These examples show that patient safety isn’t only about big hospitals or specialists — it’s everyone’s responsibility, every day.”

Step 2: Mini-Lecture – Common Patient Safety Risks

Objective: Introduce the six major categories of patient safety risks in a concise, interactive manner.

Facilitator Tips:

- Keep explanations short (5–6 minutes per topic).
- Use examples from local practice.
- After each section, ask one quick reflective question:

“Have you seen this happen in your facility?”

1. Medication Errors

“Medication errors are among the most frequent causes of patient harm in healthcare. They can occur at any stage — prescribing, dispensing, or administering.”

Do this:

- On a flip chart, draw a simple flow: *Prescription → Dispensing → Administration → Monitoring*
- Ask participants to name where errors can occur in this process.

Highlight prevention steps:

- Always confirm patient identity and drug name.
- Use standardized dosing charts.
- Label medications clearly.
- Engage patients — encourage them to ask questions.
- Record all adverse events in a medication logbook.

2. Healthcare-Associated Infections (HAIs)

“Infections acquired in healthcare settings are among the most preventable causes of harm. Hand hygiene is the single most effective measure.”

Do this:

- Demonstrate the **5 Moments for Hand Hygiene**.
- Ask: “When do you find it hardest to wash your hands properly?”
- Discuss practical solutions (e.g., pocket sanitizer, water points).

Key messages:

- Clean hands before and after every patient contact.
- Use PPE (gloves, mask, apron) when needed.
- Clean reusable instruments properly.

- Isolate or cohort infected patients when possible.

3. Diagnostic Errors

“Diagnosis errors often stem from rushing, incomplete data, or communication gaps.”

Do this:

- Present an example: “A woman treated repeatedly for malaria actually had anemia.”
- Ask: “What might have gone wrong here?”

Key prevention points:

- Use structured diagnostic checklists.
- Discuss uncertain cases with colleagues.
- Document and communicate findings clearly.
- Ensure proper follow-up and referral.

4. Unsafe Injection Practices

“Unsafe injections still cause thousands of infections every year, even though they are entirely preventable.”

Do this:

- Hold up (or show image of) a syringe and ask:

“What’s the rule?”

- Let participants answer. Reinforce:

“One needle, one syringe, one patient.”

Highlight:

- Never reuse single-use vials or syringes.

- Dispose sharps in puncture-proof boxes.
- Maintain aseptic technique always.

5. Sepsis

“Sepsis is the body’s extreme response to infection — it can lead to organ failure or death. Early recognition saves lives.”

Do this:

- Ask participants to list *three signs of sepsis*.
- Write answers: fever, confusion, low BP, fast heart rate, shortness of breath.

Prevention:

- Clean wounds promptly.
- Educate patients to seek care early.
- Use antibiotics wisely.

6. Surgical and Procedural Errors

“Even simple procedures can lead to errors — wrong site, retained items, or infections.”

Do this:

- Display or describe the **WHO Surgical Safety Checklist**.
- Emphasize: team briefing, patient identity confirmation, instrument count and sign-out.

Step 3: Group Activity – Case Scenarios

Objective: Apply learning to realistic clinical situations.

Preparation:

- Divide participants into six groups (4–6 people each).
- Hand each group one printed scenario (see below).

“Each group will analyze one real-world case. Discuss what went wrong, why it happened and how you would prevent it next time. Record your key points on a flip chart.”

Do this:

- Visit each group and encourage equal participation.
- Offer prompts:
 - “What’s the main safety issue?”
 - “Which system failed?”
 - “What action can prevent this?”

Time allocation:

- Group discussion: 10 minutes
- Preparation for presentation: 10 minutes
- Group presentations: 20 minutes

Case Scenarios

(Use these as printed handouts)

Scenario 1: Wrong Dose Given

A child received double the prescribed paracetamol dose due to a labeling error by the dispenser. The child developed vomiting and drowsiness.

→ Discuss: What went wrong? How could it be prevented?

Scenario 2: Missed Infection

A patient’s small wound was not cleaned. Two days later, infection progressed to sepsis.

→ Discuss: Which infection-control steps were missed?

Scenario 3: Unsafe Injection

Due to syringe shortage, a nurse reused a syringe after changing only the needle.

→ Discuss: What are the risks? What safer alternatives exist?

Scenario 4: Misdiagnosis

A woman with fatigue was treated for anemia for months before being diagnosed with diabetes.

→ Discuss: How could diagnostic errors be reduced?

Scenario 5: Retained Sponge

A gauze was left in a wound during a minor procedure, causing infection.

→ Discuss: How could a checklist help prevent this?

Scenario 6: Patient Misidentification

Two patients with similar names received the wrong medication.

→ Discuss: What identification procedures are needed?

Step 4: Group Presentations & Debrief

Do this:

- Invite each group to present their findings (3–4 minutes each).
- After each, open 1–2 minutes for comments from others.

Say this after all groups:

“You’ve all shown how small oversights can have serious outcomes — but also how simple actions can prevent them. Patient safety is about systems, not individuals. When we check, communicate and follow standards, everyone benefits.”

Debrief Points:

- Encourage positive examples from participants' facilities.
- Emphasize teamwork and reporting culture.
- Summarize 2–3 key takeaways per scenario.

Step 5: Summary and Reflection

“Let’s wrap up by thinking about what we can change in our daily work starting tomorrow.”

Do this:

1. On flip chart, write “Our Safety Commitments.”
2. Ask each participant to share *one action* they will take to improve safety.
3. Summarize and thank them for their contributions.

Conclude with:

“Patient safety begins with awareness and teamwork. Every one of you can make a difference through consistent small actions — clean hands, correct doses, careful checks and good communication.”

Facilitator Reflection Checklist

After the session, reflect on:

- Did all participants engage and share examples?
- Were the case scenarios relevant and understood?
- Did participants demonstrate practical understanding of prevention strategies?
- Are there follow-up actions for their facilities (e.g., starting a safety checklist)?

Post-Session Evaluation (Optional Quick Tool)

Ask participants to rate on a scale of 1–5:

1. The usefulness of the session
2. Relevance to their work
3. Confidence to apply safety practices

Then ask one open question:

“What is one thing you will do differently after this session?”

Key Takeaway Messages for Facilitators

- **Be positive and practical:** Focus on what can be done with available resources.
- **Encourage teamwork:** Reinforce shared responsibility.
- **Model safety behavior:** Demonstrate proper hand hygiene, PPE use, or verification steps.
- **Avoid blame:** Focus on learning, not fault-finding.
- **Connect local context:** Relate examples to their own PHC facilities.

Suggested Visual Aids / Slide Titles

1. Title Slide – *Common Patient Safety Risks in Primary Healthcare*
2. Learning Objectives
3. The Importance of Patient Safety
4. Medication Errors – What, Why, How to Prevent
5. Infection Prevention and Control Basics
6. Diagnostic Accuracy and Communication
7. Injection Safety
8. Sepsis – Early Recognition
9. Surgical / Procedural Safety
10. Case Scenario Instructions
11. Summary – “Every Step Counts Toward Safety”

Session Power Point Presentations

Common Patient Safety Risks in Primary Healthcare and Their Management



Khyber Pakhtunkhwa Human Capital Investment Project (KP-HCIP)

1

Learning Objectives

By the end of this session, participants will be able to:

- ✓ Identify the most common patient safety risks in PHC.
- ✓ Describe strategies for preventing medication, surgical, and diagnostic errors.
- ✓ Implement practical infection prevention and safe injection practices.
- ✓ Promote a culture of safety in their workplace.
- ✓ Participate actively in identifying and managing risks through teamwork.

2

Introduction

- Patient safety = cornerstone of quality care.
- PHC is the first contact point for most patients in Pakistan.
- Resource constraints, high workload, and limited training = higher risk of errors.

💡 **Key message:** "Every healthcare worker is a guardian of patient safety."

3

Common Patient Safety Risks

1. Medication errors
2. Surgical errors
3. Healthcare-associated infections (HAIs)
4. Diagnostic errors
5. Sepsis
6. Unsafe injection practices
7. Other preventable harms (falls, pressure ulcers, transfusion errors, misidentification)

4

SECTION 1 — Medication Errors

What Are Medication Errors?

5

Medication Errors

- Any preventable event in prescribing, dispensing, or administering a drug.
- Adverse Drug Events (ADEs) cause significant harm.
- ~1 in 30 patients experiences medication-related harm; half are preventable.

6

Prevention Strategies

- ✓ Use standardized checklists and protocols
- ✓ Adopt electronic systems (EHR, CPOE)
- ✓ Conduct medication reconciliation
- ✓ Provide team training & simulation
- ✓ Educate and involve patients
- ✓ Use unit-dose packaging

6 STRATEGIES TO REDUCE MEDICATION ERROR

Standardized Protocols	Technology
Training	Medication Reconciliation
Patient Education	Unit Dose Packaging

5 Moments for Medication Safety



**Starting
a medication**

- 1 What is the name of this medication and what is it for?
- 2 What are the risks and possible side effects?



**Taking
my medication**

- 3 When should I take this medication and how much (must) I take each time?
- 4 What should I do if I have side effects?



**Adding
a medication**

- 5 Do I really need any other medication?
- 6 Can this medication interact with any other medications?



**Reviewing
my medication**

- 7 How long should I take each medication?
- 8 Are taking any medications no longer needed?



**Stopping
my medication**

- 9 When should I stop each medication?
- 10 How to stop my medication due to an unwanted effect, where should I report this?

SECTION 2 — Surgical Errors

Surgical Errors in Healthcare

- 10% of preventable harm occurs in surgical settings.
- Common examples: wrong-site surgery, anesthesia mistakes, retained items, infections, hemorrhage, nerve damage.

Thousands of **SURGICAL ERRORS** occur every year in the United States.

Some surgical errors are classified as "preventable" because they should never occur.

TYPES OF SURGICAL ERRORS

- Anesthesia
- Medication
- Incorrect site, wrong patient, wrong procedure, and wrong person
- Wound Care
- Cardiovascular
- Neurological
- Gastrointestinal
- Respiratory

OF WSPES:

- 30% wrong site
- 23% anesthesia
- 18% medication
- 10% surgery
- 10% wound care


HOW SURGICAL ERRORS HAPPEN

- 80% Human Error
- 20% System Error

- [illegible]

Common Surgical Errors


- Operating on Wrong Site/Person:
- Anesthesia mistakes:
- Retention of foreign objects:
- Hemorrhage or Excessive Bleeding:



Prepare for Blood Loss

Get 2 IV lines if blood loss expected > 500mls

Cross match blood if more blood loss expected



UNSAFE Anaesthesia

WHEELER: Risk Management

Checklist for Anaesthesia

1. Pre-anesthetic assessment

2. Informed consent


3. Pre-oxygenation

4. Induction of anaesthesia

5. Maintenance of anaesthesia

6. Emergence from anaesthesia

7. Post-anesthetic care



Other examples of surgical errors include

- **Infections:** Inadequate sterilization techniques, improper wound care, or failure to administer proper postoperative antibiotics, resulting in surgical site infections.
- **C-Section Errors:** If the C-Section is not performed correctly or in a timely manner, it can result in injury to the mother or child.
- **Nerve Damage:** Nerves may be accidentally severed or compressed during surgery, leading to issues like numbness, paralysis, or chronic pain in the affected area.
- **Organ Perforation:** Inadvertent perforation or injury to nearby organs can happen during various surgical procedures, leading to complications.
- **Vascular Injuries:** Damage to blood vessels, such as arteries or veins, can lead to circulation problems and potentially life-threatening situations.
- **Allergic Reactions:** Neglecting to account for a patient's allergies to medications or surgical materials can result in severe allergic reactions during surgery.

[illegible]12

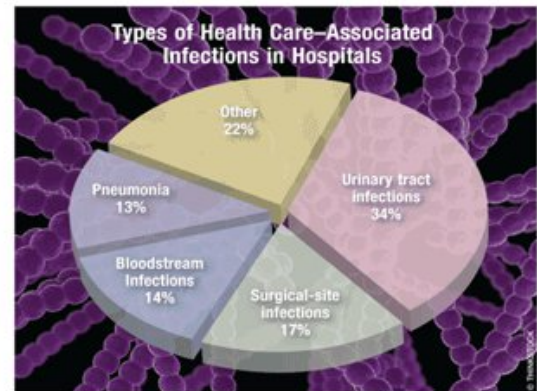
SECTION 3 — Healthcare-Associated Infections (HAIs)

Understanding HAIs

- Occur during health care for another condition.
- 4 major types: UTI, SSI, bloodstream infection, pneumonia.
- Consequences: longer stays, higher costs, AMR, and death.



13



14

CAUSES



URINARY CATHETERS
↳ URINARY TRACT INFECTIONS

SURGICAL PROCEDURES
↳ SURGICAL SITE INFECTIONS



CENTRAL VENOUS CATHETERS
↳ BLOODSTREAM INFECTIONS

MECHANICAL VENTILATION
↳ PNEUMONIA



15

Preventing HAIs

- Hand hygiene (before & after every patient contact)
- Surface disinfection and isolation when required
- Use PPE appropriately
- Follow sterilization and waste disposal protocols

What are Healthcare Workers Doing to Prevent HAIs?



16

SECTION 4 — Diagnostic Errors

Diagnostic Errors

- Failure to make an accurate or timely diagnosis.
- Often due to cognitive biases, poor communication, limited tests, or lack of follow-up.

17

Key Factors Causing Diagnostic Errors:

1. Cognitive Errors
2. Access to high quality primary care
3. Availability of health care professionals and specialists
4. Teamwork:
5. Availability of diagnostic tests
6. Communication
7. Care coordination
8. Follow-up
9. Affordability of care
10. Training of health care providers
11. Availability of health informatics resources
12. Culture
13. Human factors and cognitive issues

18

Potential solutions to reduce diagnostic errors

- ✓ Enhance Communication and Teamwork
- ✓ Utilize Technology
- ✓ Continuous Education and Training
- ✓ Standardized Diagnostic Protocols
- ✓ Patient Involvement
- ✓ Diagnostic Checklists
- ✓ Second Opinions
- ✓ Data Analysis and Feedback

19

SECTION 5 — Sepsis

- What is Sepsis?
- Body's extreme response to infection → organ failure.
- 1 in 4 hospital sepsis cases are healthcare-associated.
- Mortality ~24%.



20

Signs and Symptoms of Sepsis



21

Preventing a Sepsis Infection

- ✓ Preventing a Sepsis Infection
- ✓ Wash your hands
- ✓ Stay up-to-date on recommended vaccines
- ✓ Follow wound care instructions
- ✓ Know the signs and symptoms of sepsis
- ✓ Act fast

22

SECTION 6 — Unsafe Injection Practices

- Reusing syringes or vials
- Poor sterilization
- Improper waste disposal
- Lack of aseptic technique



Risks: HIV, Hepatitis B & C, abscesses, bloodstream infections

23

Safe Injection Practices

Safe injection practices are a set of measures taken to perform injections in an optimally safe manner for patients, healthcare personnel, and others.




24

SECTION 7 — Other Preventable Errors

Other Safety Risks

- Patient falls
- Venous thromboembolism
- Pressure ulcers
- Unsafe transfusions
- Patient misidentification

 **Tip:** Always use two identifiers — name & medical record number.

25

GROUP ACTIVITY

Instructions for all groups:

- Read your assigned scenario.
- Identify what went wrong.
- Discuss what harm could occur.
- Propose at least one preventive measure or solution.
- Present your findings in **3 minutes**.

26

GROUP ACTIVITY

Group 1: Medication Error Scenario

A Medical Officer prescribes *Amoxicillin 500 mg three times daily* for a patient with severe renal impairment, without reviewing the patient's kidney function. The nurse administers the full dose as written. Two days later, the patient develops confusion and vomiting.

Discussion Questions:

- What went wrong?
- What are the potential harms?
- What steps could have prevented this error?

Group 2: Infection Control Scenario (HAI)

A patient with a wound infection is admitted to the PHC center. Staff reuse a pair of gloves between dressing two patients because new gloves are not readily available. The second patient later develops signs of infection at the wound site.

Discussion Questions:

- What infection control practices were violated?
- What risks did this create for patients and staff?
- How can such incidents be prevented?

27

GROUP ACTIVITY

Group 3: Surgical Error Scenario

During a minor surgical procedure (lump excision), the team fails to conduct a pre-procedure verification checklist. After surgery, it's discovered that the incision was made on the **wrong arm** due to confusion in the patient file.

Discussion Questions:

- What system failure contributed to this error?
- What are the consequences for the patient and staff?
- How could this have been avoided?

Group 4: Diagnostic Error Scenario

A 40-year-old man presents with fatigue and mild shortness of breath. The clinician diagnoses "anxiety" without conducting basic tests. Two weeks later, the patient is brought to the emergency department with severe anemia due to undiagnosed gastrointestinal bleeding.

Discussion Questions:

- What cognitive or diagnostic errors occurred?
- What critical steps were missed?
- How could this diagnosis have been improved?

28

Building a Culture of Safety

- Encourage open reporting of errors (no blame).
- Conduct regular safety training.
- Support teamwork and mutual respect.
- Learn from incidents to prevent recurrence.

29

Key Takeaways

- ✓ Patient safety starts with awareness.
- ✓ Follow standard protocols and communicate clearly.
- ✓ Empower patients and involve them in care.
- ✓ Teamwork = safer outcomes.

30

Chapter 3

Developing Patient Safety Culture and Communication



Developing Patient Safety Culture and Communication

Session Overview

This session helps participants understand how to build and sustain a culture of patient safety within their organizations and strengthen communication and teamwork. Through discussion, simulation and reflection, participants will explore practical strategies for leadership, reporting, communication tools (like SBAR) and methods to engage patients and families in safety.

Learning Objectives

By the end of this session, participants will be able to:

1. Explain the key components of a patient safety culture.
2. Identify leadership, workforce and system factors that promote or hinder safety.
3. Demonstrate effective teamwork and structured communication (using SBAR, check-back, handoff tools).
4. Describe how healthcare workers can prevent harm through adherence to protocols and open communication.
5. Develop action steps to strengthen safety culture within their own facilities.

Facilitator Preparation

Before the session:

- Review this chapter and related materials.
- Prepare a PowerPoint or flip chart with the “*Framework for a Culture of Safety*”.
- Print copies of SBAR templates and communication scenarios for group work.
- Familiarize yourself with examples of local patient safety initiatives (for discussion).
- Arrange the room in small groups or U-shape to promote interaction.

Session Breakdown

Component	Method
Icebreaker & Introduction	Plenary
Mini-Lecture: Culture of Safety Framework	Interactive lecture
Group Work: Identifying Gaps and Strengths	Group activity
Mini-Lecture: Teamwork & Communication	Lecture/discussion
Role Play: Practicing SBAR Communication	Group exercise
Action Planning & Reflection	Plenary discussion

Facilitation Steps

Step 1: Icebreaker and Introduction

Objective: Introduce the concept of “safety culture” and set an open, participatory tone.

“Today’s session focuses on how we can create a *culture* where patient safety becomes part of everything we do — not an extra task, but a way of working. A safety culture isn’t built overnight; it grows from leadership, teamwork and honest communication.”

Do this:

1. Ask participants to pair up and discuss:

“What does ‘safety culture’ mean to you in your workplace?”

2. After 5 minutes, invite 2–3 volunteers to share.
3. Write key words on a flip chart: *trust, teamwork, reporting, no blame, learning*.
4. Conclude with:

“Exactly — a culture of safety means people feel safe to speak up, mistakes are seen as learning opportunities and leadership actively supports improvement.”

Step 2: Mini-Lecture – Framework for Developing a Culture of Safety

Objective: Introduce the four pillars of safety culture and discuss examples.

Facilitator Tip: Use one flip chart per pillar, with bullet points for visual support.

1. Leadership and Governance

“Safety starts at the top. Leadership must not only talk about safety but also demonstrate it through actions and resource allocation.”

Do this:

- Ask: “What actions show that leadership is committed to safety?”
- (Possible answers: regular safety meetings, budget for PPE, staff recognition, clear reporting lines.)
- Write their responses under “Leadership Commitment.”

Key Messages:

- Leadership must *prioritize* safety over blame.
- Establish clear policies and enforce accountability.
- Allocate resources for staff training and system improvements.

2. Patient and Family Engagement

“Patients and families are valuable safety partners. They notice things we may miss.”

Do this:

- Ask participants to recall a situation where a patient pointed out a potential mistake.
- Discuss how involving patients can prevent harm.

Highlight:

- Encourage patients to ask questions.
- Maintain transparent communication.
- Provide information in language they understand.

3. Learning Systems

“Every mistake or near miss should be seen as a learning opportunity.”

Do this:

- Show an example of a “near miss report” (anonymized).
- Ask: “How could we use this information to prevent future incidents?”

Key points:

- Promote continuous training and reflective learning.
- Analyze incident data to find trends.
- Apply lessons learned — not punishment.

4. Workforce Safety

“We cannot keep patients safe if our own staff don’t feel safe.”

Do this:

- Ask: “What makes staff feel unsafe or undervalued?”
- Discuss examples (lack of PPE, workload, no feedback).

Emphasize:

- Encourage non-punitive reporting.
- Recognize good safety practices.
- Build a supportive and respectful work environment.

Step 3: Group Work – Identifying Gaps and Strengths

Objective: Reflect on current culture in participants’ own facilities.

“Now let’s look at our own settings. What are we already doing well for patient safety and what still needs improvement?”

Do this:

1. Divide participants into small groups.
2. Ask them to complete a quick chart:
 - *Column 1:* What we do well
 - *Column 2:* What needs improvement
3. After 15 minutes, invite each group to share one key point.

Facilitator Note:

Capture patterns — for example, “We have reporting systems, but fear of blame remains.”

Conclude with:

“Recognizing gaps is the first step toward a strong safety culture.”

Step 4: Mini-Lecture – Teamwork and Communication

Objective: Explain the link between teamwork, communication and safety.

“Even the best systems can fail if communication fails. Many adverse events happen because critical information wasn’t shared or understood.”

Do this:

- Write “Effective Teamwork = Clear Roles + Mutual Respect + Shared Goals” on the flip chart.

- Ask participants: “What does good communication look like in your team?”

Highlight these key aspects:

- **Clear communication** – say what you mean, confirm understanding.
- **Mutual respect** – value every team member’s input.
- **Structured communication tools** – e.g., SBAR for handoffs.
- **Regular briefings/huddles** – for situational awareness.

Step 5: Role Play – Practicing SBAR Communication

Objective: Practice structured communication and feedback.

“Let’s practice how structured communication prevents confusion and improves patient outcomes. We’ll use the SBAR tool — Situation, Background, Assessment, Recommendation.”

Do this:

1. Hand out printed **SBAR templates** and sample scenarios (see below).
2. Assign each group one case and 10 minutes to prepare.
3. Have groups role-play short conversations between a nurse and doctor, or between two departments.
4. After each role play, discuss as a group:
 - Was the message clear?
 - Was all relevant information shared?
 - Was the recommendation specific?

Example SBAR Scenarios

Scenario 1:

A nurse observes that Mr. Ahmed’s blood pressure has dropped suddenly after medication.
→ How will you communicate this to the doctor using SBAR?

Scenario 2:

A patient with wound infection hasn't improved after antibiotics for 3 days.

→ Use SBAR to request review or change of plan.

Scenario 3:

A midwife notices a patient's fetal heart rate has decreased.

→ Use SBAR to escalate concern promptly.

Facilitator Notes:

- Encourage realism and empathy in tone.
- Reinforce “closed-loop communication” (repeat back and confirm).
- Praise concise, clear messages.

Conclude with:

“Structured communication saves time, reduces stress and prevents errors — especially in emergencies.”

Step 6: Action Planning and Reflection

Objective: Translate learning into practical next steps.

“We’ve discussed what makes a culture of safety and how communication strengthens it. Let’s end by deciding what actions you can take in your facility.”

Do this:

1. On flip chart, write: “What can *we* do next week to improve safety culture?”

2. Ask groups to brainstorm 2–3 practical actions (e.g., start safety huddles, introduce SBAR, encourage reporting).
3. Collect ideas and display them on wall.
4. Ask for one volunteer per group to summarize in one sentence:

“In our facility, we will start doing _____ to make care safer.”

Summarize:

- Building culture takes time — start small, stay consistent.
- Communication, respect and learning are the foundation.

Facilitator Reflection Checklist

After the session, reflect on:

- Did participants share their own experiences?
- Were examples locally relevant?
- Did role plays demonstrate clear understanding of SBAR?
- Did participants commit to at least one follow-up action?

Key Messages for Facilitators

- **Model openness:** Admit small mistakes; show learning behavior.
- **Reinforce teamwork:** Acknowledge all voices in the room.
- **Be practical:** Link concepts to participants’ daily routines.
- **Celebrate effort:** Highlight positive changes, not only gaps.
- **Promote learning, not blame.**

Session Power Point Presentation

Developing Patient Safety Culture and Communication



Khyber Pakhtunkhwa Human Capital Investment Project (KP-HCIP)

1

Session Objectives

By the end of this session, participants will be able to:

- ✓ Explain the framework for developing a culture of safety
- ✓ Describe teamwork and communication strategies for patient safety
- ✓ Identify the role of healthcare workers in preventing harm
- ✓ Recognize key communication tools that improve patient safety
- ✓ Outline steps for implementing a patient safety culture

2

Brainstorming Activity – “Building a Safer Culture Together”

Instructions for Participants:

- 👉 Form small groups (4–6 members).
- 👉 Discuss for 5–7 minutes.
- 👉 Write down your ideas on sticky notes or chart paper.
- 👉 Share 1–2 key ideas with the larger group.

3

Prompts.....

- 💡 1. What does a “**culture of safety**” look like in your department?
- 💡 2. What **barriers** prevent open communication or reporting of errors?
- 💡 3. How can we **empower staff** to speak up about patient safety concerns?
- 💡 4. What **simple changes** could improve teamwork and communication?
- 💡 5. How can patients and families be better **engaged in safety**?

4

Framework for Developing a Culture of Safety

Four Key Pillars:

- Leadership and Governance
- Patient and Family Engagement
- Learning Systems
- Workforce Safety

5

Conti...

A. Leadership and Governance

- Leadership commitment and resource allocation
- Clear safety policies and reporting procedures
- Regular monitoring and feedback
- Accountability and transparency

B. Patient and Family Engagement

- Involve patients and families in safety initiatives
- Provide education about safety practices
- Maintain transparent communication about incidents
- Encourage patients to speak up

6

Conti...

C. Learning Systems

- Continuous education and safety training
- Use of data and audits to identify risks
- Learning from incidents and near-misses
- Implementing evidence-based improvements

D. Workforce Safety

- Non-punitive error reporting systems
- Supportive work environment
- Recognition and reward for safe practices
- Staff empowerment and inclusion

7

Teamwork and Communication in Patient Safety

- Teamwork reduces medical errors and improves efficiency
- Builds trust and shared responsibility
- Encourages proactive problem-solving

Key Elements of Teamwork

1. Clear communication
2. Mutual respect
3. Structured communication tools (SBAR)
4. Training and education
5. Engaging patients and families

8

Role of Healthcare Workers in Preventing Harm

Healthcare workers should:

- Adhere to protocols and guidelines
- Communicate effectively using structured tools
- Engage patients in care decisions
- Report errors and near misses
- Use technology responsibly
- Promote teamwork and safety culture

9

Training and Empowering Healthcare Providers

Strategies:

- Comprehensive education and simulation training
- Use of technology and e-learning
- Supportive environment and mentorship
- Leadership and policy development

10

Communication Tools for Patient Safety

- ✓ **SBAR** – Structured communication
- ✓ **Check-Back** – Closed-loop verification
- ✓ **Call-Out** – Announcing critical information
- ✓ **Hand-Offs** – Standardized transfer of care
- ✓ **Patient Boards** – Visual communication in wards

11

SBAR Framework

- S – Situation:** What's happening now
- B – Background:** Relevant medical history
- A – Assessment:** What you think the problem is
- R – Recommendation:** What you suggest should be done

12



13

Other Communication Tools

- Electronic Health Records (EHRs)
- Interpreter Services
- Secure Messaging Platforms
- Checklists and Standard Protocols

14

Implementation Steps

- Establish a safety committee
- Conduct safety assessments
- Develop action plans
- Monitor progress
- Celebrate successes

15

Chapter 4

Challenges and Solutions in Implementing Quality and Safety



Challenges and Solutions in Implementing Quality and Safety

Session Overview

Purpose:

This session helps participants identify the real-world challenges in implementing quality and safety practices at primary healthcare (PHC) level and explore practical, context-specific solutions.

Session Objectives

By the end of this session, participants will be able to:

1. Identify common barriers to quality and safety in PHC settings.
2. Discuss how these challenges affect patient outcomes.
3. Explore realistic and locally appropriate solutions for overcoming these barriers.
4. Recognize the importance of leadership, teamwork and systems thinking in quality improvement.

Session Flow

Activity	Method
Introduction & brainstorming	Interactive discussion
Presentation: Common barriers	Facilitator-led with examples
Group Activity: “Challenge to Solution”	Small group work
Group sharing and facilitator summary	Group reporting
Wrap-up & key takeaways	Reflection

Facilitator Introduction

“Every healthcare worker here today plays a vital role in ensuring quality and patient safety. But we also know that many barriers stand in our way — limited resources, lack of staff, or unclear systems. Today, we’ll identify these challenges together and think of practical solutions that *fit our local context* in Khyber Pakhtunkhwa.”

Facilitation Steps:

- Ask participants: “What challenges do *you* face in providing safe and quality care at your facility?”
- Write their responses on a board.
- Group similar points (e.g., finance, workforce, management).

Discussion Prompt:

- “Which challenge do you think has the greatest impact on patient safety?”

Section 1: Common Barriers to Healthcare Quality and Safety

“Let’s explore some common barriers that affect quality and safety in PHC settings — and why they matter.”

1. Financial Constraints

- **Inadequate Funding:** Many BHUs and RHCs struggle with insufficient operational budgets.
- **Uneven Resource Allocation:** Political and administrative factors often affect fair distribution.
- **Impact:** Leads to drug stockouts, lack of basic equipment and staff shortages.

Example:

A BHU unable to maintain the vaccine cold chain due to lack of power backup — compromising immunization quality.

2. Workforce Challenges

- **Shortage of Skilled Staff:** Many rural centers lack doctors or nurses.
- **Burnout and Fatigue:** Overburdened staff compromise safety and care quality.
- **Brain Drain:** Trained workers migrate to urban or overseas jobs.

Facilitator Note:

Encourage participants to share examples from their own facilities — this helps relate the theory to their daily reality.

3. Lack of Training and Continuing Education

- Many healthcare workers rely on outdated practices.
- Limited opportunities for upskilling in safety, infection control and clinical governance.
- **Impact:** Increased risk of medication errors and poor adherence to safety protocols.

4. Inefficient Clinical Workflows

- Absence of clear SOPs results in confusion and duplication.
- Poor coordination across services (e.g., referral, laboratory, pharmacy).
- **Solution Direction:** Introduce triage systems, task-shifting and clear SOPs.

5. Weak Health Information Systems

- Most PHC centers rely on paper-based data.
- **Result:** Lost records, poor continuity of care and limited accountability.
- **Solution:** Gradual shift to electronic record-keeping and regular staff training.

6. Health Equity and Access Barriers

- Distance, poor infrastructure and lack of female providers limit service access.
- **Example:** Women in Upper Dir may delay care due to absence of female staff.
- **Solution Direction:** Outreach clinics, female health worker engagement and transport support.

7. Patient Safety Culture Gaps

- **Fear of blame** discourages error reporting.
- **Lack of standardized safety checks** (e.g., hand hygiene, injection safety).
- **Solution:** Build a “no blame” reporting culture and safety checklists.

8. Resistance to Change

- New systems often viewed as “extra work.”
- Lack of leadership communication worsens resistance.
- **Solution Direction:** Involve frontline staff early, communicate benefits and celebrate small wins.

Group Activity: “Challenge to Solution”

“Now let’s work in small groups. Each group will discuss one common challenge and propose at least two practical solutions that could work in your facility.”

Instructions for Facilitator

1. Divide participants into 4–5 small groups.
2. Assign each group one of the following topics:
 - Group 1: Financial & resource challenges
 - Group 2: Workforce & training
 - Group 3: Information systems
 - Group 4: Patient safety culture
 - Group 5: Community access & equity
3. Provide chart paper or flip chart.
4. Ask groups to note down:
 - Main challenge
 - 2–3 practical solutions
 - Key actors (who can help implement change)

Facilitator Note: Circulate among groups to guide discussions.

Group Sharing and Discussion

“Let’s hear your ideas. Remember — even small steps can make a big difference in patient safety.”

Each group presents briefly (2–3 minutes each).

Summarize and reinforce good examples:

- Use real examples from local facilities where possible.
- Highlight low-cost or policy-level solutions.

Wrap-Up and Key Takeaways

“Quality and safety challenges are real — but every challenge comes with an opportunity for improvement. Change doesn’t always need big budgets; it starts with awareness, teamwork and leadership at every level.”

Key Messages:

- Identify barriers and address them systematically.
- Invest in workforce development and training.
- Encourage open communication and error reporting.
- Engage the community and leadership for sustainable solutions.
- Promote collaboration between public, private and community actors.

Facilitator Reflection Notes

- Which barriers were most frequently mentioned by participants?
- Did participants suggest contextually appropriate solutions?
- How can the session’s findings feed into facility-level action planning or supervision visits?

Session Power Point Presentations

Challenges and Solutions in Implementing Quality and Safety



Khyber Pakhtunkhwa Human Capital Investment Project (KP-HCIP)

Learning Objectives

By the end of this session, participants will be able to:

- ✓ Identify common barriers to healthcare quality and safety
- ✓ Discuss specific challenges in primary healthcare settings
- ✓ Review policy recommendations for Khyber Pakhtunkhwa (KP)
- ✓ Recognize strategies for improving health systems and patient outcomes

Why Focus on Quality and Safety?

- Foundation of effective, equitable, and patient-centered care
- Reduces errors, improves outcomes, and builds patient trust
- Ensures optimal use of limited healthcare resources
- Supports Universal Health Coverage (UHC) and SDG 3

Common Barriers in Primary Healthcare

1. Financial constraints
2. Workforce challenges
3. Lack of training and education
4. Inefficient clinical workflows
5. Inadequate health information systems
6. Health equity issues
7. Patient safety concerns
8. Resistance to change

Financial & Workforce Barriers

- **Financial Constraints:**
 - Inadequate PHC budget and essential services
 - Political influence in allocation
 - Limited supplies and infrastructure
- **Workforce Challenges:**
 - Shortages and burnout
 - Urban-rural imbalance
 - Low motivation and retention

Training, Workflow & Information Gaps

- **Lack of Training:**
 - Outdated practices, few refresher courses
- **Inefficient Workflows:**
 - Fragmented services, poor coordination
- **Weak Health Information Systems:**
 - Paper-based records, limited interoperability

Health Equity & Patient Safety Concerns

- **Health Equity:**

Disparities due to geography and income

- **Patient Safety:**

Medication errors, infections, diagnostic delays

Underreporting due to fear of blame

7

Resistance to Change

- Reluctance to adopt new procedures or technologies

- Fear of accountability and workload

- Lack of leadership and communication

Solution: Inclusive decision-making and leadership support

8

Policy Recommendations for Khyber Pakhtunkhwa

1. Strengthen infrastructure and facilities
2. Expand and retain workforce
3. Implement quality assurance programs
4. Promote patient safety culture
5. Improve digital health systems
6. Engage communities
7. Strengthen governance and insurance

9

Budget Allocation for Primary Healthcare

- Increase and protect PHC funding

- Ensure transparent flow of funds

- Link financing to performance and outcomes

- Guarantee essential medicines and supplies




10

Moving Toward Solutions

- ☒ Systemic approach — leadership, workforce, and partnerships
- ☒ Data-driven decisions and monitoring
- ☒ Strengthen PHC for Universal Health Coverage
- ☒ Foster a learning and safety-oriented culture

11

Discussion & Brainstorming

-  What barriers are most relevant in your facility?
-  Which solutions can be implemented immediately?
-  How can we build stronger teamwork and communication?

“Quality and safety are not just policies—they are daily practices.”

12

Chapter 5

Ethical Considerations in Patient Safety



Ethical Considerations in Patient Safety

Session Overview

Purpose:

To help participants understand and apply core ethical principles in daily healthcare practice, emphasizing how ethics directly impacts patient safety and quality of care.

Session Type:

Interactive and practical — combining short lectures, real-world scenarios and small group discussions.

Session Objectives

By the end of this session, participants will be able to:

1. Explain key ethical principles that underpin safe patient care.
2. Apply ethical reasoning to real-life healthcare situations.
3. Recognize common ethical dilemmas in PHC and hospital settings.
4. Discuss practical ways to promote transparency, fairness and accountability in patient safety.
5. Commit to fostering a culture of ethical practice and reporting within their teams.

Session Flow

Activity	Method
Introduction and brainstorming	Interactive discussion
Facilitator presentation: Core ethical principles	Facilitator-led mini-lecture with examples
Group activity: “Ethics in Action”	Group discussion of case scenarios
Group presentations	Plenary sharing
Facilitator summary and discussion	Guided reflection
Wrap-up and takeaways	Key message review

Facilitator Introduction

“Patient safety and ethics go hand in hand. Every clinical decision, from prescribing a medicine to sharing a patient’s information, carries an ethical dimension. Today we’ll explore how these ethical principles guide us to do what’s right — safely, fairly and with respect for every patient.”

Activity – Brainstorm:

Ask participants:

“When you think of ethics in healthcare, what comes to mind?”

Write their responses on the board — words like *honesty, confidentiality, respect, fairness, doing no harm*, etc.

Group similar concepts together under five headings:

- Respect for autonomy
- Confidentiality
- Non-maleficence
- Beneficence
- Justice

Facilitator Tip:

Encourage sharing from both clinical and administrative perspectives. This helps connect ethics to real-life safety issues.

Section 1: Key Ethical Principles

Explain the **five foundational ethical principles** and how they apply to patient safety. For each, use **one brief explanation + one scenario discussion**.

1. Respect for Autonomy

“Respect for autonomy means allowing patients to make informed decisions about their own care — even when their choice differs from our medical opinion.”

Facilitator Points:

- Always provide clear, complete and unbiased information.
- Obtain informed consent for any procedure.
- Support the patient’s decision-making without coercion.

Scenario Discussion: *Mrs. Fatima’s Breast Cancer Decision*

Ask:

- “What did the doctor do right in this case?”
- “How can we balance respecting autonomy with ensuring patient safety?”

□ Key Takeaway:

Informed consent is not a signature — it’s a *conversation*.

2. Confidentiality

“Confidentiality builds trust. Without it, patients may hide crucial information, leading to unsafe care.”

Facilitator Points:

- Patient information must be shared only with authorized persons.
- Confidentiality applies to verbal, written and digital data.
- Breaches can lead to legal and reputational harm.

Scenario: *Confidentiality in a Busy Clinic (Mr. Khan’s Case)*

Ask:

- “What steps did Dr. Ahmed take to protect the patient’s privacy?”
- “What risks do you see in your own facility regarding patient data handling?”

Key Message:

Confidentiality ensures *trust* → *openness* → *safety*.

3. Non-Maleficence (“Do No Harm”)

“Every clinical decision should minimize risk and prevent harm — even small actions matter.”

Facilitator Points:

- Review medications and allergies carefully.
- Avoid unnecessary procedures or tests.
- Consider risks before prescribing or referring.

Scenario: *Avoiding Harm in Medication Prescription (Mrs. Ali’s NSAID case)*

Ask:

- “What ethical and safety steps did Dr. Asma take before prescribing?”
- “How does this principle apply in low-resource PHC centers?”

Key Takeaway:

Safety begins with **preventing harm**, not just responding to it.

4. Beneficence (“Do Good”)

“Beneficence means acting in the best interest of the patient — doing good through competent, compassionate and timely care.”

Facilitator Points:

- Focus on improving well-being, not just curing disease.
- Ensure continuity of care and follow-up.
- Act promptly in emergencies.

Scenario: *Emergency Appendectomy (Mr. Ali’s Case)*

Ask:

- “How did Dr. Ayesha demonstrate beneficence?”
- “What could happen if action was delayed?”

Key Message:

Beneficence is *proactive care* — anticipating and addressing patient needs.

5. Justice

“Justice means fairness — providing equal care regardless of gender, wealth, or location.”

Facilitator Points:

- Avoid bias in triage and treatment.
- Distribute limited resources fairly.
- Advocate for vulnerable and marginalized patients.

Scenario: *Ventilator Allocation During Pandemic (Dr. Azhar’s Case)*

Ask:

- “What makes this decision fair and transparent?”
- “How can justice guide difficult choices in emergencies?”

Key Message:

Justice protects trust in the health system — *patients believe care is fair.*

Section 2: Promoting Transparency and Accountability

“When things go wrong, ethical behavior means being transparent, taking responsibility and learning from mistakes.”

Facilitator Points:

- Always disclose medical errors honestly to patients and families.
- Focus on learning, not blaming.
- Build reporting systems that protect and encourage staff honesty.

Scenario 1: *Surgical Instrument Left Inside a Patient (Mrs. Khan)*

Ask:

- “How did transparency help restore trust?”
- “What system changes were made afterward?”

Scenario 2: *Follow-up Failure (Mr. Ali’s Case)*

Ask:

- “What accountability measures improved care here?”

Facilitator Tip:

Link this to local PHC systems — discuss how reporting and follow-up could be improved in participants' own facilities.

Section 3: Ethical Reporting and Oversight

“Ethical reporting helps us detect risks before they harm patients. It’s not about punishment — it’s about learning.”

Facilitator Points:

- Create safe spaces for error reporting (non-punitive culture).
- Encourage whistleblowing for unsafe practices.
- Strengthen oversight through ethics and safety committees.

Scenario 1: *Medication Error Reporting (Nurse Amina)*

Scenario 2: *Whistleblowing on Unsafe Sterilization (Dr. Ali)*

Scenario 3: *Ethics in Clinical Trials*

Ask groups:

- “What was the ethical action taken?”
- “How can your facility encourage similar transparency?”

Key Message:

Reporting + Reflection = Safer Systems.

Group Activity: “Ethics in Action”

“Now let’s test how these ethical principles apply to real-world practice. Each group will receive a case scenario. Discuss what ethical issue is involved and what actions you would take as a healthcare provider.”

Instructions:

1. Divide participants into 6 groups.
2. Assign each group one scenario (autonomy, confidentiality, non-maleficence, beneficence, justice, or transparency).
3. Ask groups to discuss and note:
 - The ethical dilemma
 - Potential risks to patient safety
 - Recommended ethical and safety actions
4. Give each group 10 minutes for discussion and 5 minutes for presentation.

Facilitator Tip:

Use probing questions — “What would you do if this happened in your facility?”

Wrap-Up and Reflection

“Ethical practice is the foundation of safe care. It builds trust, prevents harm and guides us through difficult decisions.”

Key Takeaways:

- Ethics and safety are inseparable.
- Every healthcare worker is responsible for protecting patient rights and dignity.
- Transparency and accountability strengthen trust.

- Ethical reporting promotes a culture of learning, not blame.

Reflection Question:

“What is one ethical challenge you’ve faced in your work — and how did you handle it?”

Encourage brief sharing or journaling for 2–3 minutes.

Facilitator Notes (Post-Session)

- Which ethical principles did participants relate to most strongly?
- Did participants identify practical barriers to implementing ethics (e.g., lack of time, pressure, hierarchy)?
- Follow up by encouraging each facility to develop a *simple code of ethical safety conduct* or integrate ethics discussion into monthly meetings.

Suggested Follow-Up Activity (Optional, for supervisors)

- Conduct an “Ethics Walk” — visit departments or BHUs and ask teams how they handle informed consent, confidentiality and error reporting.
- Document small improvements or good practices to share in the next supervision meeting.

Session Power Point Presentations

Ethical Considerations in Patient Safety



Khyber Pakhtunkhwa Human Capital Investment Project (KP-HCIP)

Session Objectives

By the end of this session, participants will be able to:

1. **Define** key ethical principles — autonomy, beneficence, non-maleficence, justice, confidentiality, transparency, and accountability — in the context of patient safety.
2. **Explain** how ethical principles guide safe and patient-centered clinical decision-making.
3. **Identify** common ethical dilemmas in healthcare and their implications for patient safety.
4. **Analyze** real-life case scenarios to apply ethical reasoning in clinical practice.
5. **Demonstrate** respect for patient rights through informed consent, confidentiality, and fair treatment.
6. **Participate** in group activities to brainstorm practical solutions for maintaining ethics in healthcare settings.

Introduction

Ethical considerations are essential for ensuring patient safety.
This session explores key ethical principles in healthcare practice:

1. Autonomy
2. Confidentiality
3. Non-Maleficence
4. Beneficence
5. Justice
6. Transparency & Accountability
7. Ethical Reporting & Oversight

1. Respect for Autonomy

Patients have the right to make their own healthcare decisions.

- Provide full information.
- Respect their choices.
- Obtain informed consent.



Scenario 1: Informed Decision-Making for Surgery

- Mrs. Fatima, age 60, chooses radiation over surgery for breast cancer after informed discussion with Dr. Khan.
- Outcome: Her autonomy is respected and treatment aligns with her preferences.

Scenario 2: Refusal of Treatment

- Mr. Ahmed, 75, declines high-risk surgery and opts for palliative care.
- Outcome: His decision is respected, and comfort-focused care provided.

2. Confidentiality

- Maintain privacy of patient information.
- Only share details with authorized individuals.
- Builds trust and promotes open communication.



Scenario: Confidentiality in a Busy Clinic

- A celebrity's visit is kept confidential using private consultation, secure records, and trained staff.
- Outcome: Trust and reputation are maintained.



Consequences of Breaching Confidentiality

- Loss of trust
- Legal repercussions
- Professional disciplinary actions
- Emotional harm to patients
- Impact on care and reputation
- Financial penalties

3. Non-Maleficence (Do No Harm)

- Healthcare providers must avoid causing harm.
- Includes minimizing risks and preventing medical errors.



Scenario: Avoiding Harm in Medication Prescription

- Mrs. Ali, 70, has comorbidities. Dr. Asma avoids risky medication, opts for safer alternatives, and monitors closely.
- Outcome: Harm minimized, care optimized.

4. Beneficence

- Acting in the patient's best interest.
- Promote well-being, provide quality care, and prevent harm.



Scenario: Managing Chronic Pain

- Dr. Sarah develops a personalized plan for Mr. Ahmed's chronic back pain, improving quality of life.
- Outcome: Effective pain control and improved function.

13

5. Justice in Healthcare

- Ensure fairness in treatment and access.
- Address disparities and allocate resources equitably.



14

Scenario: Equitable Allocation During Pandemic

- Dr. Azhar uses transparent criteria to allocate ventilators based on medical need.
- Outcome: Fair, unbiased, and ethical decision-making.

15

6. Transparency and Accountability

- Openly discuss errors and take responsibility.
- Improves trust and safety culture.



16

Scenario: Transparency in Medical Error

- Mrs. Khan's surgical error disclosed, corrected, and protocols improved.
- Outcome: Trust restored and system strengthened.

17

7. Ethical Reporting & Oversight

- Encourage reporting through anonymous, non-punitive systems.
- Focus on learning, not punishment.



18

Group Activity: Ethical Dilemmas in Patient Safety

Discuss one real or hypothetical ethical challenge you've faced.

Questions:

- What principle was involved?
- How was it handled?
- What would you do differently?

19

Key Takeaways

- Ethics form the foundation of patient safety.
- Respect, fairness, and accountability build trust.
- Encourage open reporting and reflection.
- Strive for continuous ethical improvement.

20