Metrics Matter

There is limited evidence to substantially describe the state of Patient Safety (PS) in the Philippines.[1,2] With most publications reflecting respondent-based assessments of institutional patient safety culture, patient-sensitive and records-based indicators are scarce.[3] Despite the Institute of Medicine's[4] call to action to address preventable errors and the publication of patient safety indicators[5], there has been slow progress in patient safety in the country.

The Department of Health's release of the National Policy on Patient Safety (Administrative Order 2008-0023)[6] and the creation of the National Patient Safety Committee (NPSC) were pivotal in elevating patient safety as priority in Philippine healthcare facilities. The creation of PS committees across hospitals and the mainstreaming of patient safety through campaigns and conferences helped push institution-level research and design programs to reduce events.[7,8] The National Policy on Patient Safety in Health Facilities (Administrative Order 2020-0007)[9] presented specific guidelines and strategies for the full implementation of PS programs, including directives on the roles and responsibilities of patient safety officers, strategies to address patient safety issues, and indicators for monitoring. The above national and institutional efforts to promote patient safety strategies are gaining momentum, but without metrics, it is impossible to determine if these initiatives result in real-world changes.

Accurate, reliable, and timely patient safety-sensitive indicators feed learning systems.[10,11] Metrics for patient safety allow for accurate analysis that translate to responsive actions to mitigate risks, ensure continuous improvement, monitor progress, and impact patient-, organization-, and health worker-related outcomes. However, the findings of incapacitated patient safety committees, missing risk management and patient-centered initiatives, and inconsistent reporting systems are highly concerning.

While hospitals have complied with the activities stipulated in the national policies, the superficial compliance reflects the lack of investment in patient safety architecture. The committee chairs and members are burdened with competing priorities, leaving them with little time to fulfil their roles in policy development, data analysis, and system improvements. These responsibilities are mere add-ons to their already brimming schedules, and the meager budget, if any, further hinders program implementation and their engagement in essential training.

Inadequate time dedicated to engaging in patient safety-focused activities of frontline healthcare personnel[12] could also explain why some patient and direct care indicators receive lower reporting than others like falls, medication errors, adverse drug events, and missed care. Reporting and contributing to learning systems can become a burden for nurses and physicians with inhumane workloads,[13-15] further exacerbating the issue.

Inconsistencies in available data can be attributed to the lack of a mature patient safety culture, resulting in reluctance to report indicators. These indicators are often regarded as a reflection of poor performance or incompetence.[16,17] Moreover, commendations for low adverse event reports and high patient satisfaction ratings perpetuate the practice of not disclosing an organization's shortcomings. A reliable baseline that indicates the severity of the situation is crucial for good results to have any significance. Without a balanced system that encourages reporting, feedback, and actionable practice changes, reports will continue to be inconsistent.

The study makes sound recommendations to use a unified set of patient safety indicators and protocols for regular measurement, analysis, and improvements integrated into a national reporting system. This system would guide collection, collation, classification, and analysis of patient safety problems that will guide improvements.[10] It starts with investing in reliable structures (personnel, funding, policies) and clear processes at the country and facility level. A culture and mindset shift are also essential to optimize patient safety structures and processes that includes a blame-free environment, the practice of enhanced feedback, champions and role models, and education and training[12,18] on core concepts in patient safety and how to analyze data to generate meaningful outcomes.

Our goal of establishing a comprehensive patient safety learning system is an arduous and complex undertaking. Achieving a high-reliability learning system necessitates the cultivation of a safety-oriented culture, which takes time to develop. However, implementing a metric for reporting and monitoring patient safety issues in hospitals would be a vital initial step toward this goal. Ultimately, the establishment of a patient safety learning system that addresses the needs of patients and healthcare workers would result in a significant improvement in patient safety outcomes.

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