MAR Clinical Case Reports (2023) 4:12

Review Article

Patient Safety Principals and Quality Control Improvement Implementations in Private Sectors in Kuwait

Yasir Zaroug *[1]

***Correspondence to:** Yasir Zaroug, family medicine diabetologist Doctor who reside in Kuwait, working in Dhaman co, Kuwait.

Received: 02 November 2023

Published: 01 December 2023

DOI: https://doi.org/10.5281/zenodo.10253722

Quality and safety in professional healthcare practice are essential aspects that ensure the well-being and satisfaction of patients **(**Hughes, 2008**)**. The IOM has tried to define health care quality via standards. First, the IOM defined quality as "the extent to which medical care for individuals and populations raise the probability of desired medical results and complies with existing professional knowledge. Listed indicators of quality, which are standards, were used to define quality. Indicator possibilities and conceptual groupings are not always standardized. Instead of positive quality indicators, most cluster of quality indicators include the 5Ds—death, disease, disability, pain, and dissatisfaction. These include effective treatment, ethical behavior, and strict protocols to reduce errors and harm **(**Lohr, 1990**)**.

The relevance and significance of healthcare safety and quality in the context of patient outcomes and public trust is that they directly impact the well-being and satisfaction of patients. When healthcare providers prioritize patient safety and deliver high-quality care, it leads to improved health outcomes for patients. This includes reducing medical errors, preventing harm, and ensuring that patients receive effective and safe care **((**WHO**)**, 2023**)**.

Furthermore, healthcare safety and quality are essential for building and maintaining public trust in healthcare systems. When patients have confidence in the safety and quality of care they receive, it enhances their trust in healthcare providers and institutions **(**Hughes, 2008**)**. This trust is crucial for patients to feel comfortable seeking healthcare services and following recommended treatments. It also reassures communities that their healthcare needs are being met and that their well-being is a priority **(**Allen-Duck, Robinson and Stewart, 2017**)**.

Investing in patient safety and quality not only improves patient outcomes but also reduces costs related to patient harm and improves the efficiency of healthcare systems. By implementing systems for incident reporting and continuous improvement, healthcare providers can identify and address areas for improvement, leading to safer and higher-quality care.

Overall, prioritizing healthcare safety and quality is essential for achieving optimal patient outcomes, maintaining public trust, and ensuring the effectiveness and sustainability of healthcare systems **(**Al-Jabri et al., 2021**)**.

Practically, DHAMAN, established in 2014 in Kuwait State, where I have worked, is the first public-private partnership **(**PPP**)** healthcare organization in the Middle East, managing an integrated healthcare system, medical insurance programs, and a network of primary healthcare centers and hospitals **(**dhman, 2023**)**.

Regarding the patient safety and quality improvement program, we established the Clinical Quality and Patient Safety Program **(**CQPS**)** in 2018 with a specialized committee and expert members, which held meetings quarterly with a report and annually with an executive plan and specific goals. Moreover, the CQPS guideline was introduced in 2019, which focuses on many areas of health care service delivery, including planning, maintenance, error incidents, patient rights, family feedback management, infection control and prevention programs, medical records documentation and coding of diagnosis and procedures, verbal telephonic contacts among care givers, occurrence variance reports, information management, disease prevention, and health promotion.

These guidelines aim to improve the overall quality of healthcare services by ensuring that healthcare providers adhere to best practices and standards. By implementing the CQPS guideline, healthcare organizations can enhance patient safety, minimize errors, and provide efficient and effective care. Additionally, these guidelines also promote transparency and accountability within the healthcare system, ultimately leading to better patient outcomes, as described profoundly by Charles Vincent et al **(**Vincent, Burnett and Carthey, 2014**)**.

In detail, I will discuss each of these parts of QCPS individually to show how we implement them in our organization and how to improve them based on recent and evidence-based guidelines in patient safety and quality improvement.

The first topic, staff health and safety programs in Dhaman: The staff health and safety program at Dhaman includes a range of guidelines and procedures to protect the safety, welfare, and health of employees, so based on the white paper **(**Hollnagel, Wears and Braithwaite, 2015**)**, we are using the Safety-One principle, which means most individuals think safety is a lack of incidents and accidents in daily life practice and taking all procedures to avoid it, so we believe a few things are going to be wrong, such as the lack of some emergency equipment of firefighters and evacuation plan in the observation room in our center in spite of regular announcements about it. These guidelines cover areas such as hazard identification and risk assessment, personal protective equipment requirements, emergency preparedness and response, and incident reporting and investigation. By implementing these measures, Dhaman aims to create an environment where employees can work safely and reduce the risk of accidents, injuries, and fatalities. Unfortunately, the safety-two principles are suboptimal and underrated, such as focusing on how things are going as well as possible and how to maintain that state. Thankfully, the organization has a flexible management committee that works to enhance our service based on recommendation reports. This is why I

am motivated to bring up safety problems at the safety committee's annual meeting. Furthermore, how can we replace the safety-one principles with a safety-two paradigm? Furthermore, Dr. Ian et al. defined safety as the absence of failure and wrong as well as doing the correct thing and being resilient in day-to-day or hourly practice. They then went on to outline five safety-tow principles, which are as follows:

1. What constitutes safety? "Safety" is described as the capacity to make things go correctly, as opposed to "Safety-I thinking," which is the absence of failures or unfavorable outcomes.
2. The goal of safety management is to preserve the ability to adapt and react appropriately to unforeseen events.
3. Humans are viewed as a resource that is essential to the adaptability and resilience of systems, rather than as a threat.
4. Accident investigation: Since understanding how things typically go wrong serves as the foundation for understanding why things occasionally go wrong, accident investigations seek to understand how things typically go correctly.
5. Understanding "conditions where performance variability can become difficult or impossible to monitor and control" is the main goal of risk assessment **(**Leistikow and Bal, 2020**)**. In order to do this, I believe the team will become more resilient and trustworthy if the safety improvement plan is implemented and daily successes are highlighted. This will encourage team members to support one another. I suggested encouraging employee involvement through participation in staff events and establishing a shared WhatsApp group as a means of effective communication **(**Hollnagel, Wears and Braithwaite, 2015**)**.

From a patient perspective, my company has made huge efforts in terms of patient experience policy and safety. We have implemented measures such as regular patient surveys and feedback sessions to ensure that their needs and concerns are addressed promptly. Additionally, we have also invested in training our staff to provide excellent customer-care service and prioritize patient safety at all times. These initiatives have significantly improved the overall patient experience and instilled a sense of trust and confidence in our clinic.

The patient reporting process goes through two stages: the first stage is the direct phone call of a customer care employee for patients to facilitate health care service and determine which specialty is needed for patient help; the second stage is the patient experience employee phone call after an appointment to assess

the quality of health care service and any difficulties or comments during care. So that, we are using the Patient Reported Experience Measure **(**PREM**)** tool in the reporting process, but unfortunately, we don't use the Patient Reported Outcome Measure **(**PROM**)**, which led to poor focus on patient outcome and missing patient feedback to improve our health care practice and provide patient-centered care. Also, patient experience employees don't share patient feedback with healthcare providers to improve health care service unless there are incidents or harm occurring, so many changes are needed based on recommendations by C. Kingsley at EL **(**Kingsley and Patel, 2017**)**. Additionally, according to Freny Shah at el, in the case of an incident or accident investigation process, our patient experience team uses a root-cause analysis method **(**RCA**)** to pinpoint the exact causes of the issue and assess the situation to provide accurate assessment and recommendations for the committee to make the right decisions **(**Shah, Falconer and Cimiotti, 2022**)**. Fortunately, after applying this method, the level of harm is going down by 50%, based on the last report.

Part Two: Quality Improvement The committee established findings in My Company in 2018. Furthermore, in 2020, the organization received full accreditation from the Joint Commission International **(**JCI**)**. One example of quality improvement is increasing the consultation time for each patient from 5 minutes to 12 minutes, which is divided into 4 minutes for history taking, 2 minutes for a specific clinical examination, and 4 minutes for the management plan and treatment, by conducting interviews, short telephonic consultations, and social media such as Instagram comments and Tweeter **(**X**)** posts for reporting that the 5-minute consultation was not enough and patients were unsatisfied, as well as health care providers who were uncomfortable, so that the committee meeting recommendation developed 12 minutes of consultation time by using the Deming cycle: Plan, Do, Study **(**PDSA**)** Act cycle **(**Best and Neuhauser, 2006**)**.

Part Three: Strategic Planning for Our Patient Safety and Quality Control Program:

As a member of the committee, I will conduct a prospective presentation about the strategic planning of introducing safety-two principles in our daily practice to avoid crises early and develop the resilience concept. I will also provide training workshops every 3 months and online lectures about safety and quality control topics by using the Team application in our company. These initiatives aim to ensure that all staff members are equipped with the necessary knowledge and skills to effectively implement safety measures and contribute to a culture of continuous improvement. Additionally, I will collaborate with other

departments to establish a reporting system for near-misses and adverse events, enabling us to identify potential areas for improvement and take proactive measures to prevent future occurrences.

References

1. Al-Jabri, F. et al. (2021) 'Quality of care and patient safety at healthcare institutions in Oman: quantitative study of the perspectives of patients and healthcare professionals', BMC health services research, 21(1), p. 1109. Available at: https://doi.org/10.1186/s12913-021-07152-2.
2. Allen-Duck, A., Robinson, J.C. and Stewart, M.W. (2017) 'Healthcare Quality: A Concept Analysis', Nursing forum. 2017/04/13, 52(4), pp. 377–386. Available at: https://doi.org/10.1111/nuf.12207.
3. Best, M. and Neuhauser, D. (2006) 'Walter A Shewhart, 1924, and the Hawthorne factory', Quality & safety in health care, 15(2), pp. 142–143. Available at: https://doi.org/10.1136/qshc.2006.018093.
4. dhman (2023) 'http://dhamanco.sharepoint.com'.
5. Hollnagel, E., Wears, R.L. and Braithwaite, J. (2015) 'From Safety-I to Safety-II: a white paper', The resilient health care net: published simultaneously by the University of Southern Denmark, University of Florida, USA, and Macquarie University, Australia [Preprint].
6. Hughes, R. (2008) 'Patient safety and quality: An evidence-based handbook for nurses'.
7. Kingsley, C. and Patel, S. (2017) 'Patient-reported outcome measures and patient-reported experience measures', BJA Education, 17(4), pp. 137–144. Available at: https://doi.org/10.1093/bjaed/mkw060.
8. Leistikow, I. and Bal, R.A. (2020) 'Resilience and regulation, an odd couple? Consequences of Safety-II on governmental regulation of healthcare quality', BMJ quality & safety. 2020/03/30, 29(10), pp. 1–2. Available at: https://doi.org/10.1136/bmjqs-2019-010610.
9. Lohr, K.N. (1990) 'MEDICARE—Vol. I—A Strategy for Quality Assurance; MEDICARE—Vol. II—A Strategy for Quality Assurance—Sources and Methods', Journal For Healthcare Quality, 12(5), p. 31. Available at: https://doi.org/10.1097/01445442-199011000-00015.

10. Shah, F., Falconer, E.A. and Cimiotti, J.P. **(**2022**)** 'Does Root Cause Analysis Improve Patient Safety? A Systematic Review at the Department of Veterans Affairs', Quality Management in Health Care, 31**(**4**)**, pp. 231–241. Available at: https://doi.org/10.1097/qmh.0000000000000344.

11. Vincent, C., Burnett, S. and Carthey, J. **(**2014**)** 'Safety measurement and monitoring in healthcare: a framework to guide clinical teams and healthcare organisations in maintaining safety', BMJ quality & safety. 2014/04/24, 23**(**8**)**, pp. 670–677. Available at: https://doi.org/10.1136/bmjqs-2013-002757.

12. **(**WHO**)**, W.H.O. **(**2023**)** 'Patient safety', Available at: https://www.who.int/news-room/fact-sheets/detail/patient-safety.