REPUBLIC OF KENYA

MINISTRY OF HEALTH

NATIONAL ACTION PLAN FOR PATIENT SAFETY, HEALTHCARE WORKER SAFETY AND QUALITY OF CARE

AUGUST 2022

Patient safety, Health Workers Safety and Quality of Care are integral components of health care systems. In developing countries, 3 in 10 patients experience adverse events and harm in hospitalized care settings. Available evidence reflects that 15% of hospital expenditure is directed to addressing the issues related to safety failures. Prevention, and reduction of adverse events and injuries arising from or during the process of healthcare is a priority in ensuring optimal patient outcomes and protecting the health worker. The Constitution of Kenya and the Kenya Health Policy, 2014–2030 demonstrates the health sector's commitment, under the government's stewardship, to ensuring that the country attains the highest possible standards of health, in a manner responsive to the needs of the population. Universal Health Coverage (UHC) is a priority at both the national and global level. The goal of UHC is to ensure that every citizen has access to quality healthcare services that they need without getting into financial difficulties or, worse, pushed into poverty.

To ensure safety and quality of care, many interventions have been undertaken within the Ministry of Health under the following initiatives: the Kenya Quality Model for Health, the Kenya Quality of Care Framework, the Joint Health Inspection Checklist, the National Infection Prevention and Control Strategy, the National Policy and Action Plan on the prevention and containment of antimicrobial resistance and the Categorization guidelines. This action plan provides a comprehensive framework through which the health care system will be transformed to deliver high quality and safer patient and family centered services. The action plan provides for health workers safety, wellness and capacity building in compassionate care; adhering to clinical and evidence-based practices promoting social medicine and community practice.

The current Kenya Quality of Care Accreditation Framework under implementation lacks the pre-requisite structures to guarantee independent, accountable and credible evaluation of safety and quality of care provided.

This action plan seeks to bridge this gap by proposing the establishment of a suitable independent entity to oversee and advise government on matters safety and quality in health care. This will guarantee a certification with a mark of quality for global recognition. This endeavor will further position Kenya as a medical tourism destination as envisioned in vision 2030.

This first Patient safety, Health Worker Safety and Quality of Care action plan, envisions a Nation where safety and quality is valued and promoted, to ensure the provision of respectful and responsive quality health care for a healthy, productive and globally competitive country. I call upon all stakeholders to commit and invest in these strategic actions to address safety and quality in health care for a healthy nation.

Sen. Mutahi Kagwe, EGH

Cabinet Secretary, Ministry of Health

The Kenya Health Policy, 2014 – 2030 gives directions to ensure the well-being of Kenyan's in line with the country's Vision 2030 and the Kenya Constitution, 2010. It focuses on ensuring equity, people centeredness and participatory approach, efficiency, multi-sectoral approach and social accountability in delivery of health care services.

The National Patient safety, Health Workers Safety and Quality of Care Action Plan, provides for a framework on interventions for safe and quality health care provision for all. This National Action Plan is the first comprehensive document addressing the safety of patients and health workers as well as quality of care and builds on the existing quality improvement initiatives such as the Kenya Quality Model for Health, the Kenya Health Care Accreditation Framework.

The health, safety and well-being of health workers is a legal and moral responsibility of governments and a prerequisite for an effective response to public health emergencies and for the provision of essential health services. This action plan provides for interventions that will ensure safe, secure and supportive working environments for all health workers.

This Action Plan is informed by the Global Patient safety Action plan endorsed in 2021 at the 74TH World Health Assembly and has received input from a diverse array of stakeholders locally and internationally through several consultative meetings.

The goal is to provide well-coordinated, pro-active, transparent, accountable and sustainable leadership and management structures at national, county and health facility levels to implement the strategy as well as involve other stakeholders from the public, private and civil society sector in its realization. The Government is committed to achieving the objectives of this Action Plan at national and county levels through mobilizing resources, to actualize, monitor and review the implementation of the interventions.

Susan Mochache, CBS

Principal Secretary, Ministry of Health

The National Action Plan on Patient safety, Health Worker Safety and Quality of Care and the accompanying Action Plan 2022-2027 was developed through a consultative process of key health stakeholders whose inputs contributed significantly in a variety of ways towards its planning and development.

Foremost, we acknowledge the Cabinet Secretary for Health whose leadership and guidance ensured that all the necessary resources and technical inputs were provided for effective planning and development of the Action Plan. We thank the technical teams from the Ministry of Health headed by the Directorate of Health Standards Quality Assurance and Regulations and support from all heads of directorates in the Ministry of Health under the leadership of the Director General for Health.

We would like to thank the Council of Governors, who through the secretariat supported and gave significant inputs to the development of the policy. The contributions from Health Professional Associations and Unions, Regulatory Boards and Councils, development and implementation partners and patient representatives brought the multisectoral approach and commitment.

Special thanks to the Division of Patient and Health Workers Safety and the Division of Quality Assurance and the technical working group, who spearheaded the whole exercise. We acknowledge the World Health Organization (WHO) for technical and financial support toward the development of these documents.

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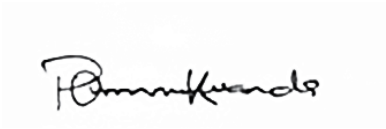


Ag. Director General, Ministry of Health

ADE	Adverse Drug Event
AMR	Antimicrobial Resistance
CASIC	County Antimicrobial Stewardship Interagency Committee
CIPCAC	County Infection Prevention Control Advisory Committee
FBO	Faith Based Organization
GPSC	Global Patient safety Collaborative
HAIs	Healthcare Associated Infections
HCW	Health workers
ICAN	Infection Control Africa Network
IPC	Infection Prevention Control
IPNET	Infection Prevention Network Kenya
KQMH	Kenya Quality Model for Health
LMIC	Low- and Middle-Income Countries
ME	Medical Errors
MOH	Ministry of Health
NPSAC	National Patient safety Advisory Council
NASIC	National Antimicrobial Stewardship Interagency Committee
NGO	Non-Governmental Organization
NHS	National Health Service
OSH	Occupational Safety and Health
PPB	Pharmacy and Poisons Board
QI	Quality Improvement
QoC	Quality of Care
UHC	Universal Health Coverage
WASH	Water Sanitation and Hygiene

1. **Adverse even**t - an unintended injury caused by medical management rather than by a disease process
2. **Patient safety incident** - any unintended or unexpected incident(s) that could have or did lead to harm for persons receiving healthcare
3. **Culture of safety** - an integrated pattern of individual and organizational behaviors based upon shared beliefs and values, that continuously seeks to minimize patient harm which may result from the processes of care delivery
4. **Harm** - temporary or permanent impairment of the physical, emotional or psychological function or structure of the body and/or pain resulting therefrom requiring intervention
5. **Health worker harm** - unintended injury acquired by a health worker in the course of their duties at their workplace.
6. **Hazard** - any source of potential harm or adverse event on someone
7. **Risk** - probability that a person will be harmed or experience an adverse health effect if exposed to a hazard
8. **Quality of care** - the degree to which health care services for individuals and populations increase the likelihood of desired health outcomes
9. **Healthcare Associated Infection** - localized or systemic condition that was not present or incubating at the time of admission into the healthcare setting and was acquired in the process of providing or receiving care
10. **Occupational diseases** – Any illness, adverse health condition or disorder which is related to exposure to substance(s) or factor(s) on the job or in the work environment
11. **Framework** – A policy framework is a document that sets out a set of procedures or goals, which might be used in negotiation or decision-making to guide a more detailed set of policies, or to guide ongoing maintenance of an organization's policies.
12. **Strategy** - A document that creates objectives and sets goals for where the organization sees itself in the long-term

1.1 Background

Patient safety is a framework of organized activities that creates cultures, processes, procedures, behaviors, technologies and environments in health care that consistently and sustainably lower risks during health care delivery. It aims to prevent and reduce the occurrence of avoidable harm, make error less likely and reduce its impact when it does occur *(WHO Global Patient safety Action Plan 2021-2030)*

The World Health Organization defines Patient safety as "The avoidance of unintended or unexpected harm to people during the provision of healthcare" (The WHO & NHS Improvement). The Canadian Patient Safety Dictionary also defines Patient safety as the "reduction and mitigation of unsafe acts within the healthcare system, as well as through the use of best practices shown to lead to optimal patient outcomes." *(The Canadian Patient Safety Dictionary, October 2003)*.

Quality of care is defined as "the degree to which health care services for individuals and populations increase the likelihood of desired health outcomes." *(Agency for Healthcare Research and Quality)*.

The Dimension that comprehensively describe the attributes of quality and safe care that are employed include: Safe, Patent centered, Effective, Efficient, Equity, Timely and Coordinated care.

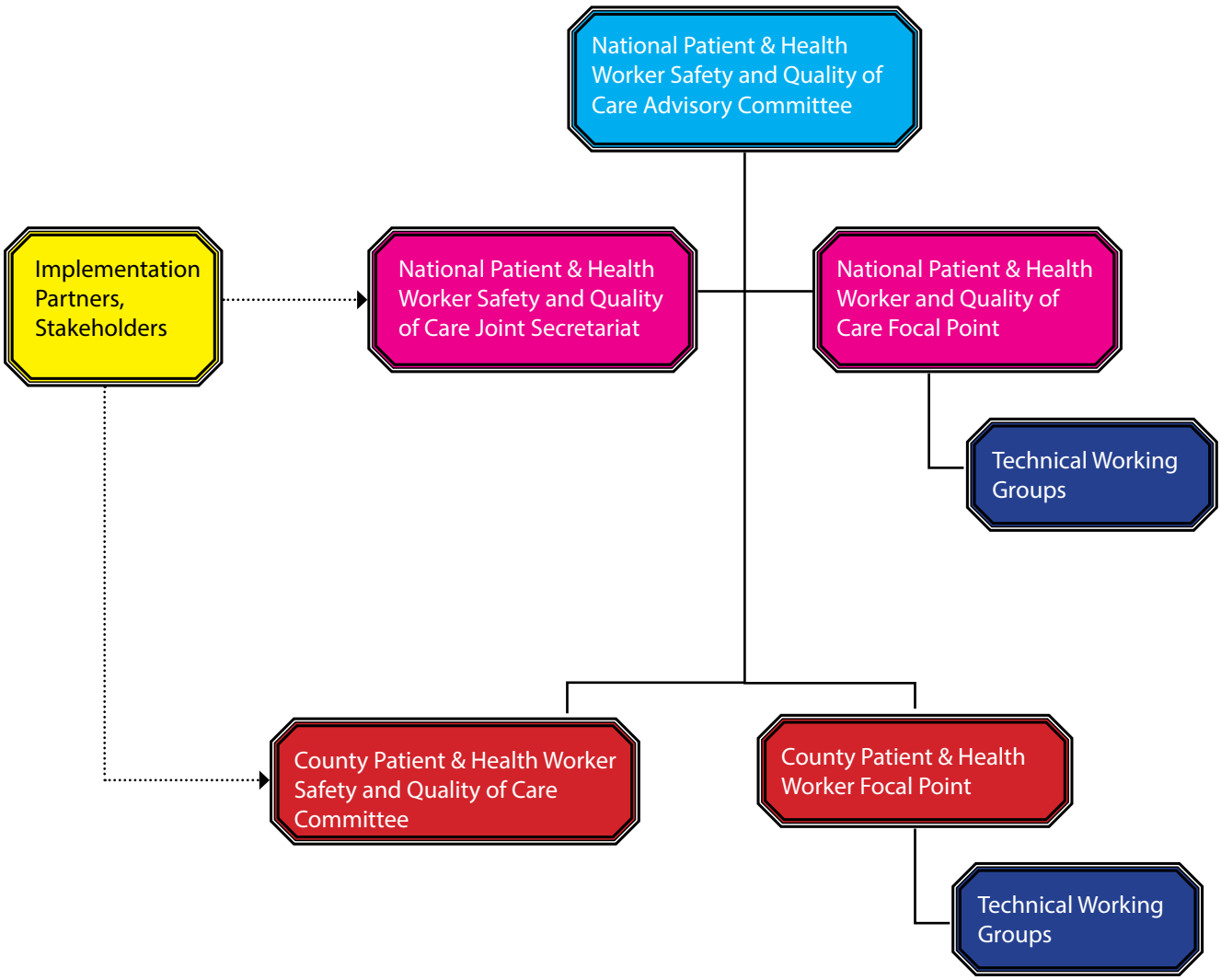
In Kenya, there are significant parallel efforts to promote patient safety, health worker safety and quality of health services. The Kenya Health Policy 2014-2030 highlights the importance of Quality, Patient and Health worker safety including organizational considerations at all levels of health care. Patient safety has been well articulated in the revised Kenya IPC Policy (2020-2025) and IPC Strategy (2020-2025), several IPC trainings packages and tools. Medication and patient safety are core components of pharmacovigilance as outlined in the Kenya Guideline on the Safety and Vigilance of Medical Products and Health Technologies 2019. In addition, health worker safety is well articulated in the Occupational Safety and Health Act No. 15 of 2007, the National Occupational Safety and Health Policy (May 2012) and the Occupational Safety and Health Policy Guidelines for the Health Sector (July 2014). Quality of care is also well articulated in the Kenya Quality Model for Health (2014), the KQMH Quality Core Standards for Quality Healthcare (March 2018) the Kenya Accreditation Framework and related Joint Health Inspection Checklists (Feb 2015) which promote compliance to minimum standards of quality and safety in health service provision.

1.2 How the action plan was developed

This action plan was developed through a process organized by the Ministry of Health, through the technical and financial assistance provided by the WHO and other partner organizations. The process was consultative under the leadership of the Division of Patient and Health worker Safety (DPHWS) and took a participatory approach that brought together various stakeholders including patient representatives, national and county governments, various levels of health facilities, regulatory bodies, health worker unions and associations, development and implementing partners who provided inputs to the document before finalization of the action plan.

The Kenyan government will lead and consolidate the efforts by individual programs or institutions through the development of policies, strategies and legal frameworks for promoting patient and health worker safety and quality of care. These efforts will encompass the different government departments, private and non-governmental sectors. A commitment from all these stakeholders will allow for the simultaneous achievement of set targets and for more resources to be generated. The government will collaborate with the civil societies, media to raise awareness and disseminate information about patient and health worker safety and quality of care.

Figure 1: Structure for Coordination Mechanism



3.1 Vision

A safe, respectful and responsive quality health care system for a healthy, productive and globally competitive nation

3.2 Mission

To build a resilient health care system with an excellent culture of safety and quality of care with minimal risks and free from preventable harm through appropriate strategies, actions, positive client experiences, and partnerships.

3.3 Goal

To improve patient and health worker safety and quality of care at all levels of the health system across the continuum of care.

No.	Strategic Objective	Strategic Interventions
1	To strengthen leadership governance and coordination mechanisms	Strengthen leadership governance, and coordination structures at all levels of healthcare
		Develop, review and implement laws, policies, guidelines, strategies and frameworks for patient and health worker safety and quality of care
		Allocate a budget to support patient and health worker safety and quality of care programs at all levels of care.
		Strengthen Implementation of the M&E framework for patient and health workers safety and quality of care
		Establish a body to oversee patient and health workers safety and quality of care at all levels
		Establish a system to provide consumer information on availability and quality of healthcare services
2	To protect the patient from avoidable harm while undergoing healthcare	Build reliable and resilient systems to support patient safety
		Promote safe clinical processes
		Improve patient and family centered care
3	To maintain health and promote the overall wellbeing of health workers by protecting them from occupational hazards	Strengthen Occupational Safety and Health (OSH) Services at all levels
		Promote transparency, openness and "no blame" culture at the workplace for incident learning and reporting
		Ensure a safe working environment through identification and control of hazards and risk management
		Provide education and training for health workers in occupational safety, incident reporting, documentation and claim processing

4	To ensure provision of quality healthcare services	Include quality and safety standards as regulatory requirements for registration and accreditation
		Empower health workers through training on safety and quality of care
		Establish structures to support quality and safety of care in health systems
		Strengthen professional competency in healthcare safety and quality of healthcare
		Enhancing positive experiences for clients and patients during utilization of health and related services
		Strengthen information management and research in safety and quality of care
		Include quality and safety standards as regulatory requirements for registration and accreditation

STRATEGIC OBJECTIVE 2: To Protect the Patient from Avoidable Harm While Undergoing Healthcare								
Expected Outcome: Reduced risk, errors and avoidable harm that occurs to patients during the provision of health care				**TIMELINES**				
Key intervention/ Strategy	**Activities**	**Indicators**	**Responsibility**	**2023**	**2024**	**2025**	**2026**	**2027**
2.1 Build resilient and reliable systems to support patient safety	Establish model sites for patient safety	No. of model sites established	Head Division responsible for safety and quality of care	x	x	x		
	Establish non-punitive patient safety incidents reporting and learning system	Incident reporting tools developed	Head Division responsible for safety and quality of care	x	x			
		No. of hospitals reporting patient safety incidents	Head Division responsible for safety and quality of care		x	x	x	x
	Adapt and mark the national patient safety day aligned with the theme of World Patient safety Day.	National patient safety day celebrated	Head Division responsible for safety and quality of care	x	x	x	x	X
		No. of Counties celebrating the patient safety day	County patient safety focal point	x	x	x	x	x
	Establish and strengthen organizational structures for patient safety at the National, County and facility level	Established patient safety committee at the National Level	Head Division responsible for safety and quality of care	x	x	x	x	X
		No. of counties with safety committees	Head Division responsible for safety and quality of care	x	x	x	x	x
		No. of facilities with safety committees	County patient safety focal point	x	x	x	x	x
		Identified safety focal point at the national level	Head Division responsible for safety and quality of care					
		No. of counties with safety focal points	County patient safety focal point					

		No. of facilities with safety focal points	County patient safety focal point					
	Advocate for incorporation of patient safety interventions into national policies, strategies and action plans	No. of national policies and strategic plans with patient safety interventions	Head, DHSQAR		x	x	x	x
2.2 Promote safe clinical processes	Incorporate patient safety activities into existing QI framework	No. of facilities with patient safety quality improvement program	Patient safety focal points at the National and County levels		x	x	x	x
	Implement AMR programs at all levels	No. of counties with AMR focal points	National AMR focal point	x	x	x	x	x
		No. of facilities with AMR focal points	County AMR focal Points					
		No. of facilities reporting on AMS	County AMR focal Points	x	x	x	x	x
	Implement surveillance of health care-associated infections and antimicrobial resistance	No. Health facilities reporting HAIs and AMR surveillance	National IPC/AMR focal point County AMR/IPC focal point	x	x	x	x	x
2.3 Improve patient and family safety centered care	Develop a patient safety charter	Patient safety charter developed	Head DPHWS		x			
	Disseminate patient safety charter	No. of facilities displaying a patient safety charter	Head DPHWS			x		

2.4 Enhance health education including pre-service training, skills and competencies	Include patient safety in induction and orientation programs as well as on-the-job trainings for staff	package for patient safety developed	Head DPHWS	x				
		No. Of hospitals reporting new staff orientation on patient safety	Head DPHWS		x	x	x	x
		No. of HWs training curriculum with patient safety component	Head DPHWS		x	x	x	x
2.5. Build capacity for research, risk management and information sharing	Incorporate a set of indicators for patient safety into the KHIS.	Patient safety indicators developed and incorporated in the KHIS	Head DPHWS		x	x	x	x
		No. Of facilities reporting patient safety incidents		x	x	x	x	x
Strategic Objective 3: To maintain health and promote the overall wellbeing of health workers by protecting them from occupational hazards.								
Expected outcome: Health workers'health maintained, wellbeing promoted and protected from occupational hazards				TIMELINES				
Key intervention/ strategy	**Activities**	**Indicator**	**Responsibility**	**2023**	**2024**	**2025**	**2026**	**2027**
3.1 Strengthen occupation- al Safety and Health Services at all levels	Establish Occupation Safety and Health committee/ focal person in all health facilities	Percentage of health facilities with Occupational Safety and Health committees/ focal persons	Head Division of OSH Head DPHWS					
	Update and disseminate Occupation safety and health policy including claims processing procedures for Occupational injuries at all levels	Proportion of National and County's department of health with policy documents and claim processing procedures disseminated	Head Division of OSH Head DPHWS					

	Revise medical examination forms and conduct medical examinations for health workers (pre, employment, Occupational peri- odic and post-employment).	Revised medical examination forms	OSH Head DPHWS Director, Directorate of occupational Health Services					
		Proportion of facilities pro-viding medical examinations for health workers (pre- periodic and post)	Head Division of OSH Head DPHWS Director, Directorate of occupational Health Services					
	Establish health worker Wellness programs at the workplace	Proportion of facilities with functional health worker wellness programs	Head Division of OSH Head DPHWS CEO/Med Supt Health Facilities					
3.2. Promote transparency, openness and "no blame" culture at the workplace for incident learning and reporting	Establish incident reporting system	Functional incident reporting system in place	Head Division of OSH Head DPHWS					
	Disseminate and distribute Health worker incident registers in all health facilities	Functional incident reporting system in place	Head Division of OSH Head DPHWS					
	Establish grievances redress mechanism for health workers	Proportion of facilities with health worker incident registers	Head Division of OSH Head DPHWS					
	Timely resolution of grievances and redress resolutions (within 90 days)	Grievances re-dress mechanism established	Head Division of OSH Head DPHWS Director, Directorate of occupational Health Services					

		Proportion of reported grievances resolved within 90 days	Head Division of OSH Head DPHWS Director, Directorate of occupational Health Services					
3.3 Ensure a safe working environment through identification and control of hazards and risk management	Develop framework for risk assessment for health workers at workplace	Framework on risk assessment developed	Head Division of OSH Head DPHWS					
	Dissemination of the risk assessment framework at all levels	Number of risk assessments for health workers reviewed	Head Division of OSH Head DPHWS					
		Percentage of health facilities implementing the risk assessment framework.	Head Division of OSH Head DPHWS					
		Number of Case investigations conducted	Head Division of OSH Head DPHWS					
3.4 Provide education and training for health workers in occupational safety and Health	Review OSH training curriculum for health workers	Revised OSH training curriculum incorporating OSH	Head Division of OSH Head DPHWS					
	Training health workers on OSH at all levels	Percentage of health workers trained on OSH	Head Division of OSH Head DPHWS					

3.5 Strengthen diagnostic capacity, information system, epidemiological surveillance and research in the field of occupational diseases, injuries and deaths.	Establish research agenda to determine working conditions and generate practical knowledge and evidence for policy decisions	Number of policy advisories informed by research on OHS	Head, Division of policy and research Head, division of OHS	x	x	x	x	x
	Conduct surveys on working conditions, health and equity	Number of surveys conducted on working conditions, health and equity	Head, Division of policy and research Head, division of OHS	x	x	x	x	x
Strategic Objective 4: To ensure provision of Quality Healthcare Services								
Expected Outcome: Improved Quality Healthcare Services				TIMELINES				
Key intervention/ Strategy	**Activities**	**Indicators**	**Responsibility**	**2023**	**2024**	**2025**	**2026**	**2027**
4.1 Include safety and quality of care standards as regulatory requirements for registration and accreditation of facilities	Implement the Quality-of-Care certification framework in 47 counties and health related SAGAs							
	Implement the Kenya Quality Model for Health (KQMH)	Proportion of health facilities assessed by joint health inspectors	KHPOA and DHSQAR; Regulators, Directors of Health, COG					
		Proportion of facilities in the county implementing the KQMH						
		Proportion of facilities scoring 50% and above in KQMH external assessment						
		Proportion of facilities partially compliant (40%-60%) in joint health inspection						

		Annual publication of health facility scores in KQMH external assessments						
4.2 Empower health workers through training on safety and quality of care	Review / develop curriculum for patient and health worker safety and quality of care for health worker training	Curriculum for safety and quality of care for health worker training developed	Director DHSQAR MOH	x				
4.3 Establish structures to support quality and safety of care in health systems	Form safety and quality improvement teams in all levels	Proportion of hospitals (L4 and above) that have reviewed TORs for QITs to include patient and health worker safety	Directorate of Health Standards, QA and Regulations;		x	x	x	x
	Develop safety and quality improvement plans in all levels	Proportion of hospitals (L4 and above) that have safety and quality improvement plans in place	Chief officers Health, COG		x	x	x	x
4.4 Strengthen professional competency in safety and quality of healthcare	Develop mentorship program for safety and quality	Mentorship program developed	Director DHSQAR			x		
	Implement mentorship program for safety and quality	Mentorship program for safety and quality available	Director DHSQAR				x	

It will be important to ensure the specific budget lines for patient safety, health worker safety and quality of care in general or for different elements of each are included in the national and county plans.

Technical and budgetary support form development and other partners can also be envisaged as per mutual agreement and based on organizational mandates and priorities.

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