Effectiveness of a WHO Safe Childbirth Checklist Coaching-based Intervention on the Availability of Essential Birth Supplies in Uttar Pradesh, India

Int J Qual Health Care 30: 769–777

Abstract

Objectives: Evaluate the impact of a World Health Organization Safe Childbirth Checklist coaching-based intervention (BetterBirth Program) on availability and procurement of essential childbirth-related supplies.

Design: Matched pair, cluster-randomized controlled trial.

Setting: Uttar Pradesh, India

Participants: 120 government-sector health facilities (60 interventions, 60 controls). Supply-availability surveys were conducted quarterly in all sites. Coaches collected supply procurement sources from intervention sites.

Intervention: Coaching targeting implementation of Checklist with data feedback and action planning.

Main Outcome Measures: Mean supply availability by study arm; change in procurement sources for intervention sites.

Results: At baseline, 6 and 12 months, the intervention sites had a mean of 20.9 (95% confidence interval (CI): 20.2–21.5); 22.4 (95% CI: 21.8–22.9) and 22.1 (95% CI: 21.4–22.8) items, respectively. Control sites had 20.8 (95% CI: 20.3–21.3); 20.9 (95% CI: 20.3–21.5) and 21.7 (95% CI: 20.8–22.6) items at the same time-points. There was a small but statistically significant higher availability in intervention sites at 6 months (difference-in-difference (DID) = 1.43, P < 0.001), which was not seen by 12 months (DID = 0.37, P = 0.53). Greater difference between intervention and control sites starting in the bottom quartile of supply availability was seen at 6 months (DID = 4.0, P = 0.0002), with no significant difference by 12 months (DID = 1.5, P = 0.154). No change was seen in procurement sources with ~5% procured by patients with some rates as high as 29% (oxytocin).

Conclusions: Implementation of the BetterBirth Program, incorporating supply availability, resulted in modest improvements with catch-up by control facilities by 12 months. Supply-chain coaching may be most beneficial in sites starting with lower supply availability. Efforts are needed to reduce reliance on patient-funding for some critical medications.

Trial Registration: ClinicalTrials.gov #NCT02148952; Universal Trial Number: U1111-1131–5647.

Effectiveness of a WHO Safe Childbirth Checklist Coaching-based Intervention on the Availability of Essential Birth Supplies in Uttar Pradesh, India

インドのウッタル・プラデーシュ州におけるWHO安全出産チェックリストに基づく指導介入が出産の際の必需品の入手しやすさに及ぼす効果

Int J Qual Health Care 30: 769–777

要旨

目的: WHO安全出産チェックリストに基づく指導介人(より良い出産のためのプログラム)が、出産の際の必需品の入手しやすさに及ぼすインパクトを評価すること。

研究デザイン: マッチドペア・クラスターランダム化比較試験。

設定: インドのウッタル・プラデーシュ州。

対象者: 政府系医療機関120施設（介入群60施設、対照群60施設）。すべての施設において、出産時必需品の入手しやすさに関する調査が4半期に1回実施された。指導員が介入群から出産時必需品の入手元の情報について収集した。

介入: チェックリストの実装に焦点を当てた指導を行い、データのフィードバックと活動計画の策定を行った。

主要評価項目: 各群の平均供給量、介入施設における供給源の変化

結果: ベースライン、6か月、12か月で、介入群は各々平均20.9項目 (95% 信頼区間 (CI): 20.2–21.5); 22.4項目 (95% CI: 21.8–22.9) と22.1項目 (95% CI: 21.4–22.8)
Patients reported 656 PSIs, most of which were medication errors and wrong sites, inpatient clinics, and geographically diverse areas of Finland.

Main Outcome Measure(s): Quantitative analysis of patients’ safety reports, inductive content analysis of patients’ suggestions to prevent the recurrence of incidents and how those suggestions were used in healthcare organizations.

Results: Patients reported 656 PSIs, most of which were classified by the healthcare organizations’ analysts as problems associated with information flow (32.6%) and medications (18%). Most of the incidents (65%) did not cause any harm to patients. About 76% of the reports suggested ways to prevent reoccurrence of PSIs, most of which were feasible, system-based amendments of processes for reviewing or administering treatment, anticipating risks or improving diligence in patient care. However, only 6% had led to practical implementation of corrective actions in the healthcare organizations.

Conclusions: The results indicate that patients report diverse PSIs and suggest practical systems-based solutions to prevent their recurrence. However, patients’ reports rarely lead to corrective actions documented in the registering system, indicating that there is substantial scope to improve utilization of patients’ reports. There is also a need for strong patient safety management, including willingness and commitment of HCPs and leaders to learn from safety incidents.

Patient-reported experiences of patient safety incidents need to be utilized more systematically in promoting safe care

Int J Qual Health Care 30: 778–785

Abstract

Objective: To analyze patient safety incidents (PSIs) reported by patients and their use in Finnish healthcare organizations.

Study Design: Cross-sectional study

Setting: About 15 Finnish healthcare organizations ranging from specialized hospital care to home care, outpatient and inpatient clinics, and geographically diverse areas of Finland.

Participants: The study population included all Finnish patients who had voluntarily reported PSI via web-based system in 2009–15.

Main Outcome Measure(s): Quantitative analysis of patients’ safety reports, inductive content analysis of patients’ suggestions to prevent the recurrence of incidents and how those suggestions were used in healthcare organizations.

Results: Patients reported 656 PSIs, most of which were classified by the healthcare organizations’ analysts as problems associated with information flow (32.6%) and medications (18%). Most of the incidents (65%) did not cause any harm to patients. About 76% of the reports suggested ways to prevent reoccurrence of PSIs, most of which were feasible, system-based amendments of processes for reviewing or administering treatment, anticipating risks or improving diligence in patient care. However, only 6% had led to practical implementation of corrective actions in the healthcare organizations.

Conclusions: The results indicate that patients report diverse PSIs and suggest practical systems-based solutions to prevent their recurrence. However, patients’ reports rarely lead to corrective actions documented in the registering system, indicating that there is substantial scope to improve utilization of patients’ reports. There is also a need for strong patient safety management, including willingness and commitment of HCPs and leaders to learn from safety incidents.

Patient-reported experiences of patient safety incidents need to be utilized more systematically in promoting safe care

Int J Qual Health Care 30: 778–785

要旨

目的：フィンランドの医療機関における患者から報告された患者安全インシデント（PSI）とその使用を分析すること。

研究デザイン：横断研究。

設定：フィンランドの約15の医療機関。専門病院から在宅医療、外来診療、入院診療に及ぶ、地理的に分散する。

主要評価項目：患者による安全性報告の定量化、再発防止のための患者の提案の帰納的内容分析、およびそれらの提案が医療機関でどのように使用されたか。

結果：患者は656人のPSIを報告し、そのほとんどは、情報の流れ（32.6%）と薬物療法（18%）に関連する問題として、医療機関のアナリストにより分類された。ほとんどの事件（65%）は患者に害を及ぼさなかった。報告の76%がPSIの再発を防ぐ方法を提案していたが、そのほとんどは実行可能で、治療の見直しまたは実施のためのプロセスのシステム・ベースの修正、リスクの予測または患者ケアにおける注意の改善であった。しかし、医療機関で是正措置を実際に実施に至ったのはわずか6%であった。
結論：結果は、患者が多様なPSIを報告し、それらの再発を防ぐための実践的なシステムベースの解決策を示唆していることを示している。しかしながら、患者の報告は、登録システムに文書化された是正措置につながることはまれで、患者報告の利用を改善する余地があることを示している。患者安全インシデントから学ぶことへのHCPとリーダーの意欲とコミットメントを含む、強力な患者安全管理も必要である。
（國澤進 Susumu Kunisawa, 今中雄一 Yuichi Imanaka）