WEEKLY EPIDEMIOLOGICAL REPORT

A publication of the Epidemiology Unit
Ministry of Health, Nutrition & Indigenous Medicine

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Patient safety

Patient safety is a fundamental principle of health care. Patient safety emphasize the reduction of risk of unnecessary harm associated with healthcare to an acceptable minimum. Every point in the process of care-giving contains a certain degree of inherent un-safety. Patients are harmed during health care, either resulting in permanent injury, increased length of stay in health care facilities, or even death.

Clear policies, organizational leadership capacity, data to drive safety improvements, skilled health care professionals and effective involvement of patients in their care, are all needed to ensure sustainable and significant improvements in the safety of health care.

Safer primary care

Primary care services are at the heart of health care in many countries. They provide an entry point into the health system and directly impact on people's well-being and their use of other health care resources. Unsafe or ineffective primary care may increase morbidity and preventable mortality, and may lead to the unnecessary use of scarce hospital and specialist resources. Thus, improving safety in primary care is essential when striving to achieve universal health coverage and the sustainability of health care. Safer primary care is fundamental to the Sustainable Development Goals, particularly to those related to ensuring healthy lives and promoting well-being for all at every age.

Patient engagement

Patient engagement is as an integral part of health care and a critical component of safe people-centered services. Patient engagement promote mutual accountability and understanding between the patients and health care providers. Primary care is often the first point of contact of patients with the health care system. Therefore, primary care offers a good starting point for further engaging patients throughout the system. Informed patients are more likely to feel confident to report both positive and negative experiences and have increased concordance with mutually agreed care management plans. This not only improves health outcomes, but also advances learning and improvement, while reducing adverse events.

Education and training

Primary care is guided by eight core principles: access or first-contact care; comprehensiveness; continuity of care; coordination; prevention; family orientation; community orientation; and person-centeredness . Ensuring that the core characteristics of primary care are included in the education process of all health care workers will help to build a health care culture where safety and quality are valued because they are central to patient well-being. Efforts to improve safety must include educating the workforce. The composition of the primary care workforce varies substantially by setting. However, regardless of the structure of the primary care workforce, pre-service and in-service education en-

Contents	*Page*

hances the safety and quality of care by ensuring that individuals are well prepared to perform their required duties, thereby reducing errors due to gaps in knowledge or skills.

Human factors

Human factors consider three domains of system design: physical, cognitive and organizational. The physical domain focuses on how the human body and physical activity interacts with work design, for example, the layout of computer desks. The cognitive domain focuses on how mental processes interact with other elements of systems. This includes memory, information processing and decision making. The organizational domain focuses on how individuals and teams interact with tools and technologies.

Administrative errors

A patient safety incident is an event or circumstance that could have resulted, or did result, in unnecessary harm to a patient. Such incidents arise from either unintended or intended acts. Errors may thus be defined as a failure to carry out a planned action as intended or the application of an incorrect plan. Errors may manifest by doing the wrong thing (errors of commission) or by failing to do the right thing (errors of omission) at either the planning or execution phase . This includes a broad range of errors, including those associated with records, tests and transitions of care.

Diagnostic errors

Errors in hospitals have been found to be significant, but it is also important to be aware of diagnostic errors in primary care. Diagnostic errors are relatively common in primary care and most people will likely experience a diagnostic error in their lifetime .

Medication errors

Many studies have described medication error rates in hospital settings, but data for primary care is relatively scarce . However, given the sheer number of prescriptions issued in primary care, there is still the potential to cause considerable harm in absolute terms. Undesirable outcomes include adverse drug reactions, drug-drug interactions, lack of efficacy, suboptimal patient adherence and poor quality of life and patient experience. In turn, these may have significant health and economic consequences, including the increased use of health services, preventable medication-related hospital admissions and death .

Multi-morbidity

People often live with many health conditions. Ageing populations and the increase in long-term conditions mean that the number of people with multiple health conditions is set to rise. This “multi-morbidity” or the coexistence of two or more chronic conditions in the same individual has a specific impact on safety issues in primary care. Patients with multi-morbidity are at higher risk of safety issues for many reasons: polypharmacy, which may lead to poor medication adherence and adverse drug events, complex management regimens, more frequent and complex interactions with health care services leading to greater susceptibility to failures of care delivery and coordination, more vulnerability to safety issues due to poor health, advanced age, cognitive impairment, limited health literacy and co-morbidity of depression or anxiety.

Transitions of care

Transitions of care are an integral part of a patient’s journey throughout a health care system. This can involve a number of interfaces between primary, community and hospital care. The constant in these transitions is the patient, and their families and care givers. Thus, it is imperative that the patient’s role and responsibilities are considered central to any strategies that support safe and effective transitions of care.

Electronic tools, or e-Health

Electronic tools, or e-Health can have an important impact on safety in primary care. Well-designed and implemented, the use of information and communication technologies in health service delivery can link health care workers with one another and with patients and families in order to provide high-quality care that is safer, more reliable, more efficient, equitable and sustainable .

Experts from around the world identified that key vulnerabilities for patient safety in every health system include communication and teamwork, ordering and interpretation of diagnostic tests, data management, transitions between levels of care, and completeness of patient records .

Every day many people are treated safely and successfully within the primary care system. Advances in technology and knowledge have made this possible, but they have also created an immensely complicated healthcare system. In this environment patient safety is of the highest importance and taking this concept forward might seem daunting.

Source:http://www.who.int/patientsafety/topics/primary-care/en/

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Table 1: Selected notifiable diseases reported by Medical Officers of Health 24th – 30th June 2017 (26thWeek)

RDHS Division	Dengue Fever		Dysentery		Encephalitis		Enteric Fever		Food Poisoning		Leptospirosis		Typhus Fever		Viral Hepatitis		Human Rabies		Chickenpox		Meningitis		Leishmani-asis		WRCD	
	A	B	A	B	A	B	A	B	A	B	A	B	A	B	A	B	A	B	A	B	A	B	A	B	T*	C**
Colombo	1338	18376	0	38	0	2	0	19	0	22	2	60	0	1	1	10	0	0	8	214	1	18	0	1	**75**	**94**
Gampaha	1444	14733	0	17	0	12	0	14	0	8	0	30	0	9	0	7	0	1	0	166	0	19	0	4	**20**	**67**
Kalutara	289	4798	1	32	0	3	0	9	0	36	4	168	0	6	0	2	0	0	1	333	1	75	0	0	**50**	**79**
Kandy	585	4429	0	57	0	4	0	4	0	9	1	28	2	89	0	9	0	1	1	151	0	26	0	7	**83**	**91**
Matale	117	1098	0	10	0	1	0	1	0	6	1	22	0	2	0	5	0	0	0	33	0	37	0	3	**54**	**77**
NuwaraEliya	24	312	0	18	0	6	1	18	0	9	0	20	0	113	1	13	0	0	3	206	0	29	0	0	**100**	**100**
Galle	106	3104	0	27	0	5	0	9	0	11	2	146	0	22	0	1	0	1	3	216	0	33	0	0	**50**	**85**
Hambantota	61	1854	0	15	0	5	0	7	0	16	0	31	0	32	0	6	0	1	0	128	2	15	1	178	**58**	**92**
Matara	87	2573	0	20	0	6	0	1	0	4	5	102	0	16	1	4	0	2	6	133	0	5	2	71	**94**	**94**
Jaffna	63	3054	0	135	0	10	1	22	6	49	0	22	0	354	0	4	0	0	1	163	2	29	0	0	**100**	**100**
Kilinochchi	5	262	0	10	0	1	0	6	0	1	0	3	1	12	0	2	0	0	0	2	0	7	0	5	**75**	**100**
Mannar	4	476	0	5	0	0	0	1	0	0	0	0	0	2	0	0	0	0	0	12	0	0	0	0	**80**	**100**
Vavuniya	19	506	0	10	0	1	0	19	1	3	0	24	0	6	0	1	0	0	0	18	0	1	0	9	**50**	**100**
Mullaitivu	10	170	0	8	0	1	0	3	0	1	0	10	0	4	0	1	0	1	0	11	0	5	0	3	**67**	**67**
Batticaloa	57	4026	0	62	0	8	0	13	0	15	0	16	0	0	0	4	0	1	0	112	0	20	0	1	**50**	**86**
Ampara	35	413	1	13	0	2	0	1	0	0	0	8	0	1	0	4	0	0	3	123	0	26	0	3	**71**	**100**
Trincomalee	21	4390	0	12	0	2	0	4	5	16	0	12	0	12	0	17	0	0	8	104	0	17	0	1	**69**	**77**
Kurunegala	306	5167	0	41	0	5	0	0	0	14	0	39	0	21	0	14	0	1	5	348	0	28	0	84	**52**	**86**
Puttalam	155	2253	0	24	0	2	0	2	0	0	0	7	0	11	0	1	0	0	0	99	0	27	0	3	**43**	**79**
Anuradhapur	60	1388	0	23	0	1	0	1	0	8	0	49	0	12	0	10	0	0	0	239	0	43	0	145	**32**	**68**
Polonnaruwa	34	1732	0	10	0	5	0	9	0	0	0	29	0	4	0	5	0	0	4	146	0	10	0	81	**57**	**86**
Badulla	34	738	2	53	0	6	0	6	0	1	2	53	2	64	0	40	0	1	13	224	4	101	0	12	**82**	**94**
Monaragala	85	1234	0	35	0	3	0	0	0	9	1	75	1	73	0	15	0	1	3	61	1	32	1	12	**100**	**100**
Ratnapura	89	1045	0	91	0	61	0	5	0	7	0	359	0	21	0	50	0	0	0	212	0	117	0	14	**28**	**72**
Kegalle	314	4894	0	25	0	8	0	4	0	15	3	45	1	50	0	11	0	0	4	161	0	45	0	5	**73**	**91**
Kalmune	298	3794	0	28	0	4	0	2	0	284	0	5	0	0	0	1	0	0	0	110	0	9	0	0	**46**	**77**
SRILANKA	**5666**	**86819**	**4**	**819**	**0**	**164**	**2**	**180**	**12**	**544**	**22**	**1356**	**7**	**937**	**3**	**237**	**0**	**11**	**63**	**3725**	**11**	**774**	**4**	**642**	**62**	**86**

Source: Weekly Returns of Communicable Diseases (WRCD).

*T=Timeliness refers to returns received on or before 30thJune , 2017 Total number of reporting units 337 Number of reporting units data provided for the current week: 301 C**-Completeness

Table 2: Vaccine-Preventable Diseases & AFP

24th – 30thJune 2017 (26thWeek)

Disease	No. of Cases by Province									Number of cases during current week in 2017	Number of cases during same week in 2016	Total number of cases to date in 2017	Total number of cases to date in 2016	Difference between the number of cases to date in 2017 & 2016
	W	C	S	N	E	NW	NC	U	Sab					
AFP*	00	00	00	01	00	00	00	00	00	01	00	40	32	25%
Diphtheria	00	00	00	00	00	00	00	00	00	00	00	00	00	0%
Mumps	00	00	01	00	00	00	01	00	00	02	05	169	207	- 18.3%
Measles	00	00	00	00	01	00	00	00	00	01	03	180	281	- 35.9%
Rubella	00	00	00	00	00	00	00	00	00	00	00	06	06	0%
CRS**	00	00	00	00	00	00	00	00	00	00	00	00	00	0%
Tetanus	00	00	00	00	00	00	00	00	00	00	00	09	04	125%
Neonatal Tetanus	00	00	00	00	00	00	00	00	00	00	00	00	00	0%
Japanese Encephalitis	00	00	00	00	00	00	00	00	00	00	00	21	05	320%
Whooping Cough	00	00	00	00	00	00	00	00	00	00	00	09	30	- 70%
Tuberculosis	11	05	01	00	04	00	13	09	08	51	260	3949	4734	-10.9%

Key to Table 1 & 2

Provinces: **W**: Western, **C**: Central, **S**: Southern, **N**: North, **E**: East, **NC**: North Central, **NW**: North Western, **U**: Uva, **Sab**: Sabaragamuwa.

RDHS Divisions: **CB**: Colombo, **GM**: Gampaha, **KL**: Kalutara, **KD**: Kandy, **ML**: Matale, **NE**: Nuwara Eliya, **GL**: Galle, **HB**: Hambantota, **MT**: Matara, **JF**: Jaffna, **KN**: Killinochchi, **MN**: Mannar, **VA**: Vavuniya, **MU**: Mullaitivu, **BT**: Batticaloa, **AM**: Ampara, **TR**: Trincomalee, **KM**: Kalmunai, **KR**: Kurunegala, **PU**: Puttalam, **AP**: Anuradhapura, **PO**: Polonnaruwa, **BD**: Badulla, **MO**: Moneragala, **RP**: Ratnapura, **KG**: Kegalle.

Data Sources:

Weekly Return of Communicable Diseases: Diphtheria, Measles, Tetanus, Neonatal Tetanus, Whooping Cough, Chickenpox, Meningitis, Mumps., Rubella, CRS,

Special Surveillance: AFP* (Acute Flaccid Paralysis), Japanese Encephalitis

CRS** =Congenital Rubella Syndrome

Dengue Prevention and Control Health Messages

Look for plants such as bamboo, bohemia, rampe and banana in your surroundings and maintain them

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Comments and contributions for publication in the WER Sri Lanka are welcome. However, the editor reserves the right to accept or reject items for publication. All correspondence should be mailed to The Editor, WER Sri Lanka, Epidemiological Unit, P.O. Box 1567, Colombo or sent by E-mail to **chepid@sltnet.lk. Prior approval should be obtained from the Epidemiology Unit before publishing data in this publication**

ON STATE SERVICE

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