MINISTRY OF HEALTH AND CHILD CARE

QUALITY ASSURANCE AND PATIENT SAFETY DIRECTORATE

MANUAL FOR ON-THE-JOB SAFE ENVIRONMENT ACTIVITY

1st Edition, March 2026

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Background

Zimbabwe has been implementing 5S-KAIZEN-TQM approach since 2015. In addition, after ZIM-QIPS started in 2022, the 14 target hospitals have made efforts to improve quality services through 5S-KAIZEN activities and have established an organized work environment. Building on this progress, ZIM-QIPS proposes implementing the On-the-Job Safe Environment Activity aiming at identifying and eliminating potential hazards in working environment and healthcare service provision process. Continuous implementation of this initiative will enhance staff awareness of the potential hazards and promote a culture of safety within hospitals.

Purpose of the activity

- ✓ To encourage the fostering a safety culture in the target hospitals.

Objectives

- ✓ To increase awareness of safety in the workplace among the healthcare providers
- ✓ To identify potential hazards in the workplace and healthcare service provision process
- ✓ To take prompt and appropriate actions to mitigate the identified hazards.

Target

Frontline staff in the hospitals.

When to practice

Since the procedure of this activity is simple, easy for everyone to do regardless cadres of hospital staff as well as types of the departments, this activity can be practiced during the following activities:

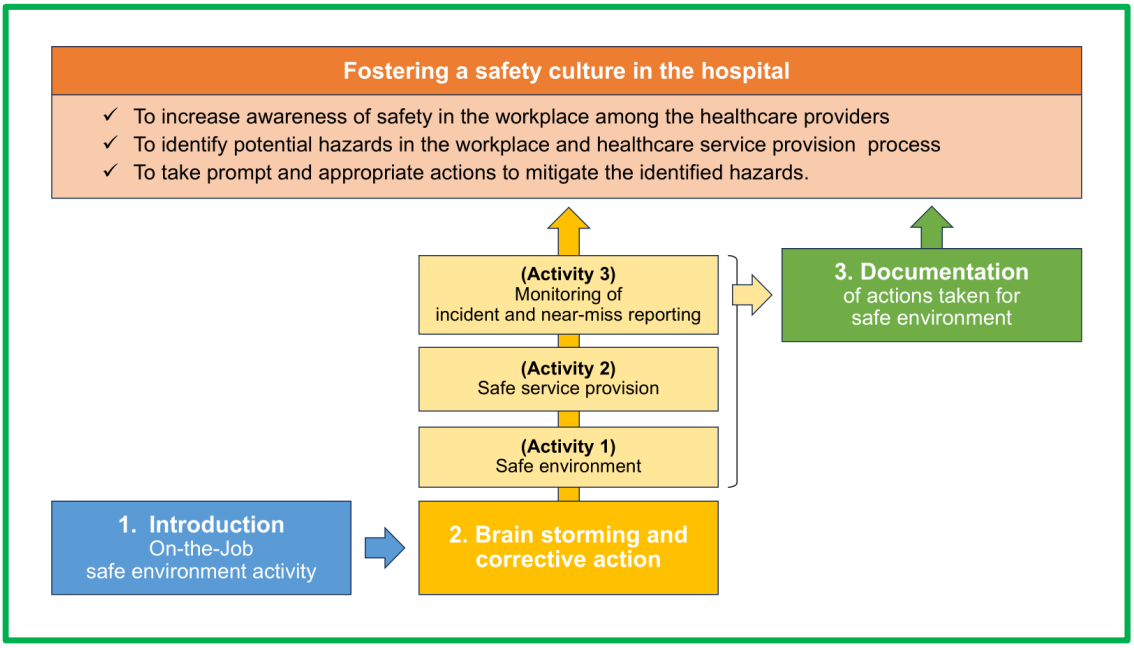
- ✓ Hospital round by the hospital managers
- ✓ Internal monitoring and/or evaluation organized by QIT/QAD
- ✓ Different meetings (e.g., WIT meeting, Ward meeting)
- ✓ Induction course or orientation for new employee including residents

Knowledge and skills for facilitator

Facilitator will be required to have the following knowledge and skills to lead the activity:

- ✓ Knowledge on safety, non-blame culture, learning from mistakes, 5S activity
- ✓ Active listening skill
- ✓ Coaching skill, which is a skill that involve drawing out thoughts and ideas from the person being coached rather than presenting them with the ideas for solutions

Procedure of On-the-Job Safety Environment Activity



1. Introduction

The facilitator will explain the purpose and the objectives of the activity, including the reminding the frontline staff of the following three fundamental concept for safety culture at healthcare facility.

- "To err is human", meaning that everyone makes mistakes.
- Particularly, services at a healthcare facility (clinical care and treatment) involve risks, and negative incidents may easily occur.
- To eliminate errors, clinical risk management should be implemented to improve the quality and safety of healthcare services by identifying potential hazards that put patients at risk of harm and then acting to prevent or control those risks.

2. Brainstorming and corrective action

This procedure should be in the order from Activity 1 to 3.

- First of all, **Activity 1** ensures the effectiveness of the 5S activities in the work environment, considering potential hazards.
- Then, **Activity 2** will help to standardize and visualize service processes to ensure a common understanding among the frontline staff. The standardized operating procedures developed through Activity 2 will enhance frontline staff's awareness of incidents and near-misses.
- Finally, **Activity 3** will effectively promote the incident report system and contribute proactively to improving service quality and safety.

➢ Activity 1: Safe environment

Medical errors can be attributed to the following six factors. In order to ensure patient safety, each factor should be systematically addressed through appropriate measures. Among these, environmental factors can be most effectively mitigated through the implementation of 5S and Quick KAIZEN activities. Review the workplace by checking the environmental factors of medical errors, and update 5S/Quick KAIZEN activities accordingly.

The factors of medical errors[1]

- Patient factor and provider factors
- Task factors
- Technology and tool factors
- Team factors
- **Environmental factors: Physical space (movement flow), Layout (look-alike, sound-alike), Lighting, Noise**
- Organizational factors

(1) The facilitator will select a target site (item, equipment, space, etc.) need to be improved to avoid potential hazards.

(2) The facilitator will let frontline staff to think about safe environment, as followings;
- What is the purpose of utility of the target site?
- Who are the users of the target site?
- Whether the place setting the target site is appropriate for the users?
- Whether the place setting the target site is appropriate for patients and their families?
- What potential hazards can be identified?

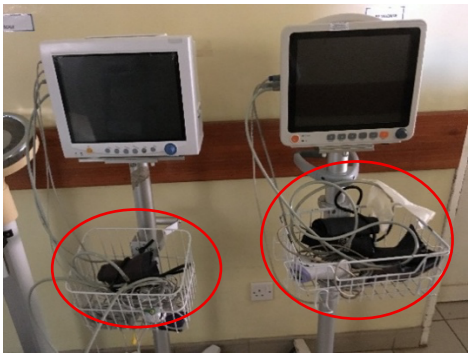
(3) The facilitator will ask frontline staff to find corrective action(s), considering the following points.
- Rearrange the placement (*sort, set, shine*) of the target equipment to avoid the potential hazards.
- Create a SOP/checklist to standardize the corrected usage of the target equipment among the team. (*standardize, sustain*)

(4) The facilitator will encourage the frontline staff to take the initiative in this activity as part of their routine work to further improve work environment.

Examples of target site

Physical space (movement flow)	
	The sharps box is placed in the corridor, with zoning and a label. However, since the corridor is used not only by staff but also patients and their families, there is a potential hazard of someone might accidentally touch or bump into it. Therefore, the staff need to identify an appropriate and safe place to place the box.

[1] Patient Safety Curriculum Guide: multi-professional edition (WHO 2011)

	The patient monitors are properly kept in the designated place. However, the items in the basket are mixed up with unnecessary ones and are not on standby for immediate use. There is a potential hazard that the unavailability of it might have a serious effect on the emergency treatment for a patient. Therefore, it is necessary to place only the necessary items in the basket and set them on standby.
Layout (look-alike, sound-alike)	
	Three different medicines are stored in small packages using the same plastic bag and kept in look-alike boxes. There is a potential hazard of wrong medication to a patient by picking up wrong medicines. Therefore, clear labeling and signboards are required.
	The acid concentrate for dialysis and the liquid cleaning solution were stored on the same shelf. Both bottles look alike. There is a potential hazard of mistaking the bottles and misusing them. It might have a serious effect on the treatment for a patient. Therefore, storing these bottles separately, providing clear labeling, and indicating precautions for use are required.
Lighting	
	The records of the department's quality activities are displayed on the windows. However, they block nature light from entering the room. There is a potential hazard of misreading or miswriting documents, which could have a serious effect on patient treatment. Therefore, relocating the record display is necessary to allow as much natural light in as possible.

➢ Activity 2: Safe service provision

Error is an inevitable part of being human. A unique feature of health care-associated errors is that when failure occurs, it is the patient who suffers. Therefore, clinical risk management is essential. The standardization of common processes and procedures is one of the strategies to help reduce human error.

The strategies to help reduce human error[1]

- Avoid reliance on memory
- Make things visible
- Simplify processes
- **Standardize common processes and procedures**
- Routinely use checklists
- Decrease reliance on vigilance.

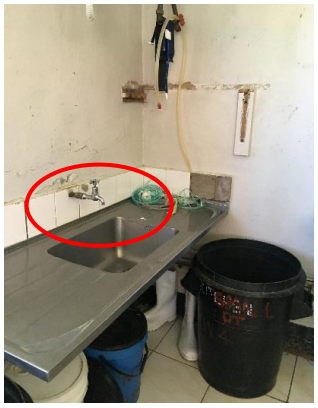
(1) The facilitator will select a target service process need to be improved to avoid potential hazards.

(2) The facilitator will let frontline staff to think about safe service provision, as followings;
- How to do the target service process? (Request a demonstration.)
- What potential hazards can be identified?
- The same process is recognized among the frontline staff?
- The standardized process is documented and shared among the frontline staff?

(3) The facilitator will advise correcting the procedure considering potential hazards and ask frontline staff to create a SOP/checklist to standardize the service process.

(4) The facilitator will encourage the frontline staff to take the initiative in this activity as part of their routine work to further improve service provision.

Examples of Target service process

Standardizing common processes and procedures	
	The kits for collecting blood sample are properly set. However, there are no standardized procedures, and the process is not unified. Creating an SOP for blood sample collection, considering potential hazards such as the following, is required. • Patient misidentification • Needlestick injury • Inappropriate waste management
	The used items are in place without being cleaned or removed. It is required to create an SOP for sterilization of used items, which includes the person in charge during each shift and takes into account potential hazards such as the following. • Unified protocol of sterilization • IPC

	In kitchen departments, maintaining hygiene in the environment, among staff, and throughout work processes are fundamental. Creating specific SOPs for departmental hygiene and presenting them visually to ensure staff awareness is essential to eliminate potential hazards.
	In a mortuary department, the main role of frontline staff is to handle deceased patients who may have suffered from various diseases; therefore, they should strictly IPC measures. Moreover, frontline staff must ensure proper identification of the deceased. To ensure effective IPC and accurate identification, it is essential to develop original SOPs for the department and present them visually to promote staff awareness and prevent potential hazards.

➢ Activity 3: Monitoring of incident and near-miss reporting

Safety culture is that health-care professionals strive to operationalize through the implementation of strong safety management systems. “Non-punitive reporting system” and “Learning from incidents” are part of pillars for effective safety culture.

Pillars for effective safety culture

- Leadership commitment
- Open communication
- Education and training
- **Non-punitive reporting system (Blame-free reporting)**
- Engaging staff in all level
- Implementing safety protocols and checklists
- Measuring and monitoring safety performance
- Patient and family involvement
- **Learning from incidents**
- Building a just culture

(1) The facilitator will ask frontline staff about the followings regarding the incident and near-miss reports:
   - The number of reports collected during the last three months.
   - Whether responses to the reported incidents and near-misses have been implemented, and its lessons learnt are shared with other departments.

(2) The facilitator will encourage frontline staff to continue to collect incident and near-miss reports by conveying the following points regarding reporting incident and near-misses.
    - The primary purpose of incident and near-miss reporting is to enhance patient safety by identifying patterns and trends in incidents to prevent recurrence and improve care processes.
    - Reporting is not intended to blame individuals involved in the incident.
    - Staff awareness of incidents and near-misses is essential for continuous quality improvement.
    - A healthcare facility that encourages frequent reporting can be considered safer, as it reflects a culture where frontline staff learn from each other to further improve safety.

(3) The facilitator will encourage QIT to continue collecting incident and near-miss reports from the departments in order to understand the safety status of the hospital and learn from errors by following these processes:
    - Review and analyze the processes and the background factors of incidents or near-misses
    - Develop countermeasures for incidents or near-misses
    - Share the lessons learnt with all departments to prevent recurrence.

3. Documentation of actions taken for safe environment

(1) The facilitator will ask frontline staff to express their impressions and comments about the safe environment activities.

(2) The facilitator encourages frontline staff to document the actions taken and their results from safe environment activities in the “5S/Quick KAIZEN” format (See the Annex), and to share them with QIT and other departments as a good practice.

ANNEX: Good Practice Sheet of 5S/Quick KAIZEN Activity

Date of implementation of Quick KAIZEN	
Name of facility	
Name of department	

Objectives of 5S / Quick KAIZEN (Select <u>maximum three</u> items)

- □ Productivity / Efficiency of work
- □ Cost reduced
- □ Staff safety
- □ Patient safety
- □ Communication among staff
- □ Communication with patients
- □ Other ( )

Picture before (Date:)	**Picture after** (Date:)

Description of situation before Quick KAIZEN (Describe challenges before Quick KAIZEN)	**Description of situation after Quick KAIZEN** (Describe achievements and benefits by Quick KAIZEN)

Actions taken as Quick KAIZEN
(Describe what you did to address the challenges and change the situation for the better)

Any action for maintaining the positive effect by Quick KAIZEN	**The date shared to QIT**

Project for Quality Improvement of Health Service through 5S-Kaizen-TQM Approach