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From Policy to Practice: Assessing Patient Safety Program Implementation in Government Hospitals in Albay, Philippines

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***Abstract*—** This study assessed the implementation of patient safety programs in selected government hospitals in Albay, Philippines, focusing on compliance levels, system gaps, and implementation challenges. A descriptive survey design was used involving six government hospitals classified as infirmary and Level I facilities. Data were gathered using a structured questionnaire adapted from the Department of Health's Integrated Hospital Operations Management Program patient safety component. Descriptive statistics, including frequency counts and mean scores, were used to analyze compliance levels. Findings showed that several components were fully complied with, including quality nursing documentation, functional infection prevention and control committees, food safety and nutrition care, diagnostic processes, and patient safety committees. However, clinical audit, pharmacovigilance, functional IPC units, IPC assessment tool accomplishment, root cause analysis, and system-based patient safety indicators were only partially complied with. Major challenges included limited budget allocation, high staff turnover, limited training opportunities, inadequate staffing, high workload, and difficulty sustaining IPC practices. The study concludes that patient safety structures are present but inconsistently operationalized. Strengthening clinical audits, pharmacovigilance, IPC monitoring, root cause analysis, workforce support, and non-punitive reporting systems is recommended to improve patient safety implementation in government hospitals.

***Keywords*—** patient safety; government hospitals; implementation; Philippines.

I. INTRODUCTION

Patient safety remains one of the most important concerns in contemporary health care systems because preventable harm continues to occur despite the existence of clinical standards, regulatory mechanisms, and quality improvement initiatives. The World Health Organization defines patient safety as the absence of preventable harm and the reduction of unnecessary risks associated with health care to an acceptable minimum (World Health Organization [WHO], 2023). Globally, unsafe care contributes to avoidable morbidity, mortality, disability, prolonged hospitalization, and increased healthcare costs. The Global Patient Safety Action Plan 2021–2030 emphasizes that patient safety should be treated as a strategic priority for all health systems and not merely as a technical or clinical issue (WHO, 2021). This is particularly important in public hospitals, where service demand is high and institutional resources may be limited.

Patient safety is closely linked to healthcare quality, organizational culture, leadership, and system design. Earlier landmark work by the Institute of Medicine highlighted that medical errors are often not simply the result of individual negligence but arise from weaknesses in healthcare systems, including poor communication, inadequate monitoring, and fragmented processes (Kohn, Corrigan, & Donaldson, 2000). Similarly, Reason's (2000) Swiss Cheese Model explains that adverse events occur when multiple layers of system defenses fail, allowing hazards to reach patients. These perspectives support the shift from blaming individuals to examining the organizational and systemic factors that contribute to unsafe care. Therefore, patient safety programs must focus not only on policies and compliance but also on strengthening reporting systems, learning mechanisms, clinical governance, and continuous quality improvement.

In many countries, including the Philippines, patient safety has become an important regulatory and policy concern. The Department of Health issued Administrative Order No. 2020-0007 to strengthen the implementation of patient safety policies in health facilities and align healthcare delivery with national quality and safety standards (Department of Health, Philippines, 2020). This policy direction reflects the recognition that patient safety must be institutionalized across health facilities through structures such as patient safety committees, infection prevention and control systems, clinical audits, pharmacovigilance mechanisms, documentation standards, and incident reporting processes. However, the presence of policies does not automatically ensure their full implementation. In practice, healthcare facilities may vary in their capacity to translate national policies into routine clinical and administrative operations.

The implementation of patient safety programs is especially challenging in resource-constrained public healthcare settings. Studies in developing country contexts have shown that inadequate staffing, limited resources, insufficient training, and weak organizational support affect patient safety culture and compliance with safety standards (Alquwez et al., 2021). These challenges are highly relevant to government hospitals, which often serve a large proportion of the population while operating under budgetary and workforce limitations. In such settings, patient safety programs may exist formally, but implementation may be inconsistent due to competing priorities, staff turnover, workload pressures, and limited monitoring systems. These conditions may weaken the ability of hospitals to sustain safety practices and prevent adverse events.

Governance and leadership are central to effective patient safety implementation. The Agency for Healthcare Research and Quality (AHRQ, 2019) emphasizes that a strong patient safety culture requires leadership commitment, open communication, teamwork, organizational learning, and non-punitive responses to error. Clinical governance systems are also important because they establish accountability structures for monitoring risks, evaluating clinical practice, and improving care processes. Jiji Lucas et al. (2022) found that leadership, risk management, and clinical practice monitoring are strongly associated with improvements in patient safety outcomes. These findings suggest that patient safety committees and hospital leadership must not only exist formally but must also actively guide, monitor, and sustain safety-related activities.

Specific patient safety components are also critical in reducing preventable harm. Clinical audits and morbidity–mortality reviews provide structured mechanisms for evaluating clinical practice and identifying opportunities for improvement (Vincent, 2010). Pharmacovigilance systems are essential for detecting, assessing, and preventing adverse drug reactions and medication errors, which remain among the most common preventable causes of patient harm (Kohn et al., 2000). Nursing documentation supports continuity of care, communication among healthcare professionals, legal accountability, and clinical decision-making (Obioma, 2017). Food safety and nutrition care processes also contribute to patient safety by reducing risks related to diet therapy, contamination, and inappropriate nutritional management (Canuto et al., 2023; Roberts et al., 2019). These components demonstrate that patient safety is multidimensional and requires coordinated action across clinical, administrative, and support services.

Infection prevention and control is another major component of patient safety. Functional infection prevention and control committees, trained personnel, written policies, monitoring tools, and regular assessment processes are needed to reduce healthcare-associated infections and protect both patients and healthcare workers. The WHO (2021) identifies infection prevention, incident reporting, surveillance, and learning systems as essential elements of patient safety improvement. However, even when infection prevention structures are present, gaps may remain in implementation, documentation, monitoring, and sustainability. These gaps may be more visible in smaller or resource-limited hospitals where designated infection prevention personnel, training opportunities, and operational resources may be insufficient.

A system-based approach is necessary to ensure that patient safety programs are sustained and integrated into routine hospital operations. Donabedian's Structure–Process–Outcome framework provides a useful lens for understanding patient safety implementation because it shows how hospital structures, such as staffing, policies, committees, and resources, influence care processes and outcomes. Meanwhile, Reason's systems-based theory emphasizes that harm is often produced by multiple organizational weaknesses rather than isolated individual failures (Reason, 2000). Together, these frameworks support the need to assess not only whether patient safety structures exist but also whether they are functional, consistently implemented, monitored, and used for organizational learning.

This study is important because it provides localized evidence on the implementation of patient safety programs in selected government hospitals in Albay, Philippines. While national patient safety policies are already in place, there remains a need to examine how these policies are operationalized in government hospitals at the provincial level. The study contributes to the understanding of implementation gaps, compliance levels, and system challenges affecting patient safety in public healthcare facilities. Its findings may inform hospital administrators, provincial health authorities, and policymakers in strengthening patient safety governance, improving resource allocation, enhancing monitoring systems, and promoting a non-punitive culture of reporting and learning.

Specifically, this study aimed to: (1) describe the profile of participating government hospitals in terms of facility level, scope of services, licensing status, and bed capacity; (2) determine the level of implementation of key patient safety program components, including patient safety committees, clinical audits, pharmacovigilance, nursing documentation, food safety and nutrition care, diagnostic processes, infection prevention and control, IPC assessment, and root cause analysis; (3) identify the major challenges encountered by government hospitals in implementing patient safety programs; (4) examine the extent to which participating hospitals apply a system-based approach to patient safety, including policy alignment, continuous quality improvement, patient feedback, and review of clinical outcomes; and (5) propose evidence-based recommendations for strengthening patient safety implementation in government hospitals.

II. METHODOLOGY

This study employed a descriptive survey research design to assess the implementation of patient safety programs in six selected government hospitals in Albay, Philippines. The design was appropriate because the study aimed to describe existing patient safety structures, processes, compliance levels, and implementation gaps without introducing any intervention. The participating facilities included infirmary and Level I government hospitals, and the respondents were designated patient safety officers, infection prevention and control nurses, or authorized representatives familiar with hospital safety systems.

Data were collected using a structured questionnaire adapted from the Department of Health's Integrated Hospital Operations Management Program (IHOMP), particularly the patient safety component. The tool gathered information on hospital profile, implementation of patient safety program components, challenges encountered, and adoption of system-based patient safety practices. Key areas assessed included patient safety committees, clinical audits, pharmacovigilance, nursing documentation, diagnostic processes, food safety and nutrition care, infection prevention and control, IPC assessment, and root cause analysis.

Quantitative data were analyzed using descriptive statistics, particularly mean scores and frequency counts. A three-point compliance scale was used: 1.34–2.00 = Fully Complied, 0.67–1.33 = Partially Complied, and 0.00–0.66 = Not Complied. Ethical considerations were observed by securing permission from relevant authorities, obtaining informed consent from respondents, maintaining confidentiality, and anonymizing participating facilities throughout the study.

III. RESULTS

Profile of the participating government hospitals

Table 1 presents the profile of the six participating government hospitals included in the study. The profile variables consisted of facility level, scope of services, licensing status, and bed capacity. These characteristics provide important contextual information regarding the structural capacity of the hospitals and their readiness to implement patient safety programs.

The findings show that the participating hospitals were equally distributed between infirmaries and Level I hospitals, with three facilities (50.0%) belonging to each category. This distribution suggests that the study captured healthcare facilities with varying levels of organizational complexity and service capability. While both facility types provide essential healthcare services, Level I hospitals generally possess greater capacity to manage a wider range of clinical services compared to infirmaries.

Such differences in organizational structure may influence the availability of resources, staffing patterns, and implementation of patient safety initiatives.

Table 1. *Profile of Participating Government Hospitals in Albay (n = 6)*

Variable	f	%
Facility Level		
Infirmary	3	50.0
Level I Hospital	3	50.0
Scope of Services		
General Services	6	100.0
Licensing Status		
Licensed	6	100.0
Bed Capacity	Mean = 40.5 beds	Range = 18–100

In terms of service provision, all six hospitals (100.0%) reported offering general services. This indicates a relatively uniform service mandate across the participating facilities, allowing for a more consistent assessment of patient safety implementation. Likewise, all hospitals were licensed by the Department of Health, demonstrating compliance with national regulatory requirements and minimum operational standards. The universal licensing status suggests that the facilities have met the basic structural requirements necessary for healthcare delivery. However, compliance with licensing requirements alone does not necessarily guarantee effective implementation of patient safety systems, as operational practices and organizational culture also play critical roles in ensuring safe patient care.

The mean authorized bed capacity of the participating hospitals was 40.5 beds, with capacities ranging from 18 to 100 beds. This finding indicates that most facilities operate on a relatively small to medium scale. Variations in bed capacity may have implications for patient safety implementation, as larger facilities often have greater access to human resources, infrastructure, and support systems, whereas smaller facilities may encounter limitations in staffing, training opportunities, and quality improvement activities. Consequently, differences in hospital size and capacity may influence the extent to which patient safety programs are implemented and sustained.

These findings are consistent with the principles of Donabedian's Structure–Process–Outcome framework, which posits that healthcare structures, including facility size, organizational capacity, and available resources, influence the processes and outcomes of care. Similar observations have been reported by Alquwez et al. (2021), who found that structural limitations and resource constraints in healthcare facilities significantly affect the implementation of patient safety practices. The World Health Organization (2021) likewise emphasizes that adequate organizational capacity and institutional support are essential foundations for achieving

effective patient safety systems. Furthermore, the Agency for Healthcare Research and Quality (AHRQ, 2019) highlights that organizational characteristics, leadership support, and resource availability are important determinants of a strong patient safety culture. These studies support the view that hospital profile characteristics provide an important context for understanding variations in patient safety program implementation across healthcare facilities.

Level of implementation of key patient safety program components

Table 2 presents the level of implementation of key patient safety program components among the participating government hospitals in Albay. The assessment covered critical areas of patient safety, including governance structures, clinical processes, medication safety, nursing documentation, infection prevention and control (IPC), food and nutrition services, diagnostic systems, and quality improvement mechanisms. The findings provide an overview of the extent to which patient safety standards are being implemented across the participating facilities.

The results indicate that several patient safety components were fully complied with, demonstrating the existence of important safety structures and processes within the hospitals. Quality Nursing Documentation and Functional IPC Committees obtained the highest mean score of 2.00, indicating consistent implementation across all facilities. Food Safety, Appropriate Diet and Nutrition Care Process (1.83), IPC Policies and Procedures (1.83), Patient Safety Committee (1.50), and Diagnostic Process (1.50) were likewise interpreted as fully complied. These findings suggest that hospitals have generally institutionalized essential patient safety mechanisms related to documentation, infection prevention, nutrition services, governance, and diagnostic support. The high compliance in nursing documentation may reflect the recognition of accurate and timely documentation as a fundamental component of safe patient care and continuity of treatment.

Table 2. *Level of Implementation of Patient Safety Program Components in Government Hospitals*

Patient Safety Component	Mean Score	Interpretation
Patient Safety Committee	1.50	Fully Complied
Clinical Audit	1.33	Partially Complied
Pharmacovigilance	1.17	Partially Complied
Quality Nursing Documentation	2.00	Fully Complied
Food Safety, Appropriate Diet, and Nutrition Care Process	1.83	Fully Complied
Diagnostic Process	1.50	Fully Complied
Functional IPC Committee	2.00	Fully Complied
Functional IPC Unit	1.33	Partially Complied
IPC Policies and Procedures	1.83	Fully Complied
Accomplishment of IPC Assessment Tool (IPCAT)	1.33	Partially Complied
Root Cause Analysis (RCA)	0.67	Partially Complied

Despite these positive findings, several patient safety components were only partially complied with, indicating gaps in implementation and opportunities for improvement. Clinical Audit (1.33), Functional IPC Unit (1.33), Accomplishment of IPC Assessment Tool or IPCAT (1.33), Pharmacovigilance (1.17), and Root Cause Analysis (0.67) all fell within the partially complied category. The relatively lower scores in these areas suggest that although policies and systems may exist, their implementation remains inconsistent or inadequately supported. In particular, Root Cause Analysis received the lowest mean score, indicating that systematic investigation of adverse events and identification of underlying causes are not yet fully institutionalized across the participating hospitals. Similarly, the partial implementation of pharmacovigilance may limit the abilit y of facilities to detect, monitor, and prevent medication-related adverse events.

The findings further reveal a pattern in which hospitals demonstrate stronger compliance with structural and administrative components of patient safety than with monitoring, evaluation, and continuous improvement mechanisms. While committees, policies, and documentation systems are generally established, activities requiring continuous surveillance, incident analysis, and organizational learning appear to be less consistently implemented. This suggests that the hospitals have made progress in establishing foundational patient safety structures but continue to face challenges in translating these structures into fully functional and sustainable safety systems. Such a situation may expose healthcare facilities to preventable risks and limit opportunities for organizational learning and quality improvement.

The results support the proposition of Donabedian's Structure–Process–Outcome framework that effective patient safety outcomes require not only the presence of structures but also the consistent implementation of safety processes. Similarly, James Reason's Swiss Cheese Model emphasizes that weaknesses in monitoring, reporting, and incident analysis create vulnerabilities that may allow adverse events to occur. The findings are consistent with those of Jiji Lucas et al. (2022), who reported that clinical governance systems, particularly leadership, risk management, and clinical practice monitoring, are strongly associated with improved patient safety outcomes.

The strong performance in nursing documentation supports the findings of Obioma (2017), who emphasized that accurate documentation enhances communication, clinical decision-making, and patient safety. The partial compliance observed in pharmacovigilance aligns with the findings of Kohn, Corrigan, and Donaldson (2000), who identified medication-related incidents as major sources of preventable patient harm and emphasized the need for robust medication safety systems.

Likewise, the findings on infection prevention and control support the World Health Organization's Global Patient Safety Action Plan (2021), which highlights functional IPC programs, surveillance systems, and continuous monitoring as essential strategies for reducing healthcare-associated infections and improving patient safety.

Overall, the findings suggest that while foundational patient safety systems are present in the participating hospitals, strengthening audit mechanisms, pharmacovigilance, root cause analysis, and continuous monitoring processes remains necessary to achieve a more comprehensive and sustainable patient safety culture.

Major challenges encountered by government hospitals in implementing patient safety programs

Table 3 presents the challenges encountered by the participating government hospitals in implementing patient safety programs. Understanding these barriers is essential because the successful implementation of patient safety initiatives depends not only on the presence of policies and guidelines but also on the availability of resources, workforce capacity, organizational commitment, and a supportive safety culture. The identified challenges provide insight into the factors that may limit the effectiveness and sustainability of patient safety efforts within the participating facilities.

Table 3. *Challenges Encountered in the Implementation of Patient Safety Programs*

Challenge	f	Rank
Limited budget allocation	6	1
High staff turnover	5	2
Limited training opportunities	5	2
Inadequate staffing and high workload	4	3
Challenges in sustaining IPC practices	4	3
Weak reporting culture	3	4
Limited monitoring and evaluation mechanisms	3	4
Insufficient leadership engagement and support	2	5
Absence of a fully functional Patient Safety Committee	1	6

The findings reveal that limited budget allocation was the most commonly reported challenge, identified by all six participating hospitals. This indicates that financial constraints remain the most significant barrier to patient safety implementation. Insufficient funding may restrict hospitals from investing in staff development, quality improvement initiatives, infection prevention and control activities, monitoring systems, and necessary equipment. The universal reporting of this challenge suggests that patient safety programs often compete with other operational priorities for limited healthcare resources, particularly in government-funded facilities.

The second-ranked challenges were high staff turnover and limited training opportunities, both reported by five hospitals. These findings suggest that workforce-related issues continue to affect the continuity and effectiveness of patient safety programs. High staff turnover may result in the loss of institutional knowledge, disruption of established safety practices, and increased demands for orientation and retraining. Similarly, limited training opportunities may prevent healthcare workers from developing competencies necessary for implementing patient safety interventions, incident reporting, infection prevention and control, and quality improvement activities. Together, these challenges may contribute to inconsistent adherence to patient safety standards and reduced organizational learning.

The study also found that inadequate staffing and high workload and challenges in sustaining infection prevention and control (IPC) practices were reported by four hospitals. These findings indicate that human resource limitations remain a significant concern. Staffing shortages may increase workload demands on healthcare personnel, potentially contributing to fatigue, reduced compliance with safety protocols, and a higher likelihood of errors.

Difficulties in sustaining IPC practices may further compromise patient safety by increasing the risk of healthcare-associated infections and weakening infection prevention efforts. These findings suggest that maintaining safe healthcare environments requires not only established policies but also sufficient personnel and operational support.

Meanwhile, weak reporting culture and limited monitoring and evaluation mechanisms were identified by three hospitals, while insufficient leadership engagement and support was reported by two hospitals. These organizational challenges may impede the development of a proactive patient safety culture. Weak reporting systems may discourage healthcare workers from reporting incidents, near misses, and adverse events, thereby reducing opportunities for organizational learning and quality improvement.

Similarly, inadequate monitoring and evaluation mechanisms may hinder the identification of implementation gaps and limit evidence-based decision-making. Although only one hospital reported the absence of a fully functional Patient Safety Committee, the findings suggest that the functionality and effectiveness of existing governance structures may vary among facilities.

Overall, the findings demonstrate that the challenges encountered by the hospitals are multifactorial and interconnected. Financial limitations, workforce shortages, inadequate training, weak reporting systems, and limited leadership support collectively influence the implementation of patient safety programs. These barriers may contribute to inconsistencies in compliance and hinder the achievement of a comprehensive culture of safety within healthcare facilities.

The findings are consistent with the World Health Organization Global Patient Safety Action Plan 2021–2030, which identifies inadequate resources, workforce shortages, and weak safety cultures as major barriers to patient safety implementation, particularly in low- and middle-income countries.

Similarly, Alquwez et al. (2021) reported that insufficient staffing, limited organizational support, and resource constraints negatively affect patient safety culture and compliance with safety standards.

The importance of continuous staff development is supported by Verano, who emphasized that leadership and ongoing training are critical determinants of patient safety culture in healthcare organizations. Furthermore, Reason (2000) argued that patient safety failures often arise from multiple systemic weaknesses rather than individual errors alone, highlighting the importance of addressing organizational deficiencies such as poor reporting mechanisms, inadequate monitoring systems, and weak governance structures.

These studies support the present findings and underscore the need for increased resource allocation, workforce strengthening, leadership engagement, and the development of a non-punitive learning culture to improve patient safety implementation in government hospitals.

The extent to which participating hospitals apply a system-based approach to patient safety

Table 4 presents the extent to which the participating government hospitals adopted a system-based approach to patient safety.

The assessment focused on key indicators of organizational commitment to patient safety, including the adoption of systems thinking, alignment of policies with national standards, implementation of Continuous Quality Improvement (CQI) programs, integration of patient feedback into service improvement, and regular review of clinical outcomes.

These indicators reflect the extent to which patient safety is embedded within organizational processes and continuous improvement mechanisms rather than being treated as isolated activities.

Table 4. *Extent of Adoption of a System-Based Patient Safety Framework*

Indicator	Mean Score	Interpretation
Facility adopts a system approach to patient safety	1.17	Partially Complied
Policies align with National Patient Safety Standards	1.00	Partially Complied
Continuous Quality Improvement (CQI) programs are implemented	1.17	Partially Complied
Patient feedback is incorporated into service improvement	1.33	Partially Complied
Regular review of clinical outcomes	1.17	Partially Complied
Overall Mean	1.17	Partially Complied

The findings indicate that all indicators were interpreted as Partially Complied, with mean scores ranging from 1.00 to 1.33 and an overall mean score of 1.17. This suggests that while elements of a system-based patient safety framework are present in the participating hospitals, their implementation remains incomplete and inconsistent. The partial compliance across all indicators implies that hospitals have initiated efforts to integrate patient safety into their organizational systems but have not yet achieved full institutionalization of these practices.

Among the indicators assessed, patient feedback incorporated into service improvement obtained the highest mean score (1.33), although it remained within the partially complied category. This finding suggests that hospitals recognize the importance of patient engagement and are making efforts to utilize patient experiences and concerns in improving healthcare services. Patient feedback serves as an important source of information for identifying service gaps, enhancing patient-centered care, and promoting quality improvement. However, the partial compliance rating indicates that mechanisms for systematically collecting, analyzing, and acting upon patient feedback may not yet be fully established across all facilities.

The indicators facility adopts a system approach to patient safety, implementation of Continuous Quality Improvement (CQI) programs, and regular review of clinical outcomes each obtained a mean score of 1.17, indicating partial compliance. These findings suggest that although hospitals have begun incorporating systems-based safety principles into their operations, such efforts may not yet be consistently practiced or

fully integrated into routine management processes. Continuous quality improvement and regular review of clinical outcomes are essential components of patient safety because they enable healthcare organizations to identify performance gaps, monitor progress, and implement corrective actions. The findings imply that opportunities for organizational learning and continuous improvement may not be fully maximized within the participating hospitals.

The lowest mean score was observed in policy alignment with National Patient Safety Standards (1.00), which also fell within the partially complied category. This result indicates that while patient safety policies may exist, their alignment with national standards may not be comprehensive or consistently implemented. Policy alignment is crucial because it provides a structured framework for guiding safety practices, ensuring regulatory compliance, and supporting quality improvement initiatives. Partial compliance in this area suggests that gaps may exist between policy development and operational implementation, potentially affecting the consistency of patient safety practices across healthcare facilities.

Overall, the findings indicate that the participating hospitals have established the foundational elements of a system-based patient safety framework but continue to face challenges in achieving full integration and sustainability. The partial compliance observed across all indicators suggests the need for stronger organizational commitment, enhanced monitoring systems, improved policy implementation, and greater emphasis on continuous quality improvement. Without fully operational system-based approaches, patient safety efforts may remain fragmented and less effective in preventing adverse events and promoting organizational learning.

These findings support Donabedian's Structure–Process–Outcome framework, which emphasizes that effective healthcare outcomes depend on the interaction between organizational structures and the processes through which care is delivered.

The results also align with Reason's (2000) Swiss Cheese Model, which highlights the importance of strengthening multiple layers of organizational defenses to prevent system failures and adverse events. Furthermore, the findings are consistent with the World Health Organization's Global Patient Safety Action Plan 2021–2030, which advocates for systems-based approaches, continuous quality improvement, patient engagement, and organizational learning as essential strategies for improving patient safety. Similarly, Lungu and Harvey (2023) emphasized that patient safety interventions are most effective when they are systematically integrated, continuously monitored, and sustained within healthcare organizations.

The importance of leadership, feedback systems, and organizational learning is further supported by AHRQ (2019), which identified these elements as fundamental characteristics of a strong patient safety culture. Collectively, these studies reinforce the present findings and highlight the need for government hospitals to strengthen policy alignment, institutionalize continuous quality improvement activities, enhance patient engagement mechanisms, and establish robust systems for monitoring clinical outcomes to achieve a more comprehensive and sustainable patient safety framework.

Evidence-based recommendations for strengthening patient safety implementation in government hospitals

Table 5 presents the key gaps identified in the implementation of patient safety programs and the recommended actions for strengthening these programs. The recommendations are based on the study findings and focus on areas that were only partially complied with or identified as major implementation challenges.

First, the study recommends the institutionalization of regular clinical audits and morbidity–mortality reviews because clinical audit obtained a mean score of 1.33, interpreted as partially complied.

Regular audits can help hospitals identify gaps in clinical practice, evaluate patient outcomes, and implement corrective actions.

This recommendation is important because clinical audits serve as a structured mechanism for continuous quality improvement and organizational learning.

Second, the study recommends strengthening adverse drug reaction and medication-error reporting systems because pharmacovigilance had a mean score of 1.17, also interpreted as partially complied. Weak pharmacovigilance may limit the ability of hospitals to detect medication-related risks and prevent recurrence of adverse drug events. Improving medication safety reporting systems would support early detection, documentation, and prevention of medication errors.

Table 5. *Summary of Key Gaps and Recommended Actions for Strengthening Patient Safety Programs*

Identified Gap	Evidence from Thesis Findings	Recommended Action
Inconsistent conduct of clinical audits	Clinical audit had a mean score of 1.33, interpreted as Partially Complied.	Institutionalize regular clinical audits and morbidity–mortality reviews.
Weak pharmacovigilance implementation	Pharmacovigilance had a mean score of 1.17, interpreted as Partially Complied.	Strengthen ADR and medication-error reporting systems.
Limited functionality of IPC units	Functional IPC Unit had a mean score of 1.33, interpreted as Partially Complied.	Designate trained IPC personnel and provide regular IPC capacity-building.
Incomplete accomplishment of IPC assessment tools	IPCAT accomplishment had a mean score of 1.33, interpreted as Partially Complied.	Require regular IPCAT completion, validation, and monitoring.
Limited use of root cause analysis	RCA had a mean score of 0.67, interpreted as Partially Complied.	Establish mandatory RCA procedures for adverse events and HAIs.
Budget and staffing constraints	Limited budget was reported by 6/6 hospitals; inadequate staffing and high workload by 4/6 hospitals.	Advocate dedicated patient safety funding and workforce strengthening.
High staff turnover and limited training	High staff turnover and limited training opportunities were each reported by 5/6 hospitals.	Implement retention strategies and continuous patient safety training.
Weak reporting culture	Weak reporting culture was reported by 3/6 hospitals.	Promote a non-punitive reporting and learning culture.
Partial system-based implementation	All system-based framework indicators were interpreted as Partially Complied, with mean scores ranging from 1.00 to 1.33.	Strengthen CQI programs, patient feedback systems, policy

Third, the study recommends designating trained IPC personnel, providing regular IPC capacity-building, and requiring consistent completion, validation, and monitoring of IPC assessment tools. These recommendations are supported by the partial compliance scores for Functional IPC Unit and IPCAT accomplishment, both with a mean score of 1.33. Although IPC committees and policies were present, the findings indicate that IPC implementation still requires stronger operational support, monitoring, and staff competency development.

Fourth, the study recommends establishing mandatory Root Cause Analysis procedures for adverse events and healthcare-associated infections because RCA obtained the lowest mean score of 0.67. This finding suggests that systematic investigation of adverse events is not yet fully institutionalized. Strengthening

RCA would help hospitals move from a reactive approach to a learning-oriented system that identifies underlying causes of patient safety incidents.

Fifth, the study recommends dedicated patient safety funding, workforce strengthening, staff retention strategies, and continuous patient safety training. These recommendations are supported by the finding that limited budget was reported by all six hospitals, inadequate staffing and high workload by four hospitals, and high staff turnover and limited training opportunities by five hospitals. These workforce and resource constraints may weaken implementation, reduce continuity of safety practices, and limit staff capacity to comply with patient safety standards.

Finally, the study recommends promoting a non-punitive reporting and learning culture and strengthening CQI programs, patient feedback systems, policy alignment, and outcome monitoring. These are supported by the reported weak reporting culture in three hospitals and the partial compliance of all system-based framework indicators, with mean scores ranging from 1.00 to 1.33. These findings indicate that patient safety programs should not focus only on compliance but also on building a culture of learning, feedback, and continuous improvement.

These recommendations are supported by existing patient safety literature. Vincent (2010) emphasized the value of clinical review and learning systems in improving healthcare safety, while Kohn, Corrigan, and Donaldson (2000) highlighted medication errors and system failures as major causes of preventable harm. Reason's (2000) Swiss Cheese Model supports the use of root cause analysis and system-based prevention strategies. The World Health Organization (2021) also emphasizes continuous quality improvement, incident reporting, patient engagement, and strong institutional systems as essential elements of patient safety. Similarly, Alquwez et al. (2021) and AHRQ (2019) support the importance of leadership, staffing, training, and non-punitive safety culture in strengthening patient safety implementation.

IV. CONCLUSION & RECOMMENDATION

The study concludes that patient safety programs in participating government hospitals in Albay are generally established but remain inconsistently implemented. While core structures such as patient safety committees, IPC committees, nursing documentation, food safety, and diagnostic processes showed full compliance, important safety mechanisms such as clinical audits, pharmacovigilance, IPC units, IPC assessment tools, root cause analysis, and system-based quality improvement remained only partially complied with. The findings indicate that patient safety implementation is affected by resource limitations, workforce challenges, limited training, weak reporting culture, and incomplete integration of system-based approaches.

Government hospitals should strengthen patient safety implementation by institutionalizing regular clinical audits, pharmacovigilance reporting, IPC monitoring, IPCAT completion, and mandatory root cause analysis for adverse events. Dedicated funding should be allocated for patient safety activities, staff training, and workforce support. Hospitals should also develop retention strategies, reduce workload pressures, and promote a non-punitive reporting culture that encourages learning from errors. At the system level, patient safety committees should actively monitor compliance, strengthen CQI programs, incorporate patient feedback, regularly review clinical outcomes, and align hospital policies with national patient safety standards.

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