

# Implementation of the patient safety incident guidelines in district health services, Western Cape

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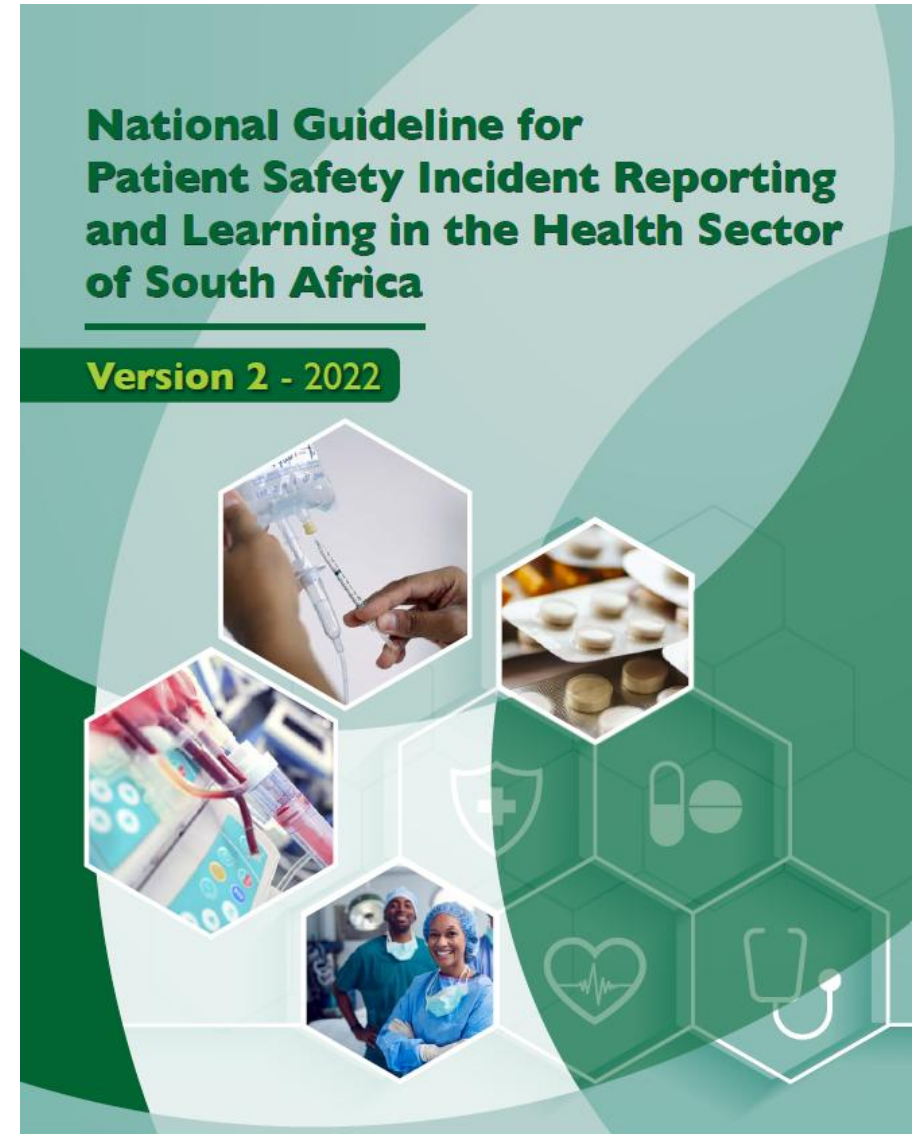
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# Introduction

A patient safety incident (PSI) is:

“an unplanned or unintended event or circumstance that could have resulted or did result in harm to a patient while in the care of a health facility. This event is thus not because of the underlying health condition or the natural progression of the disease.”



# Introduction

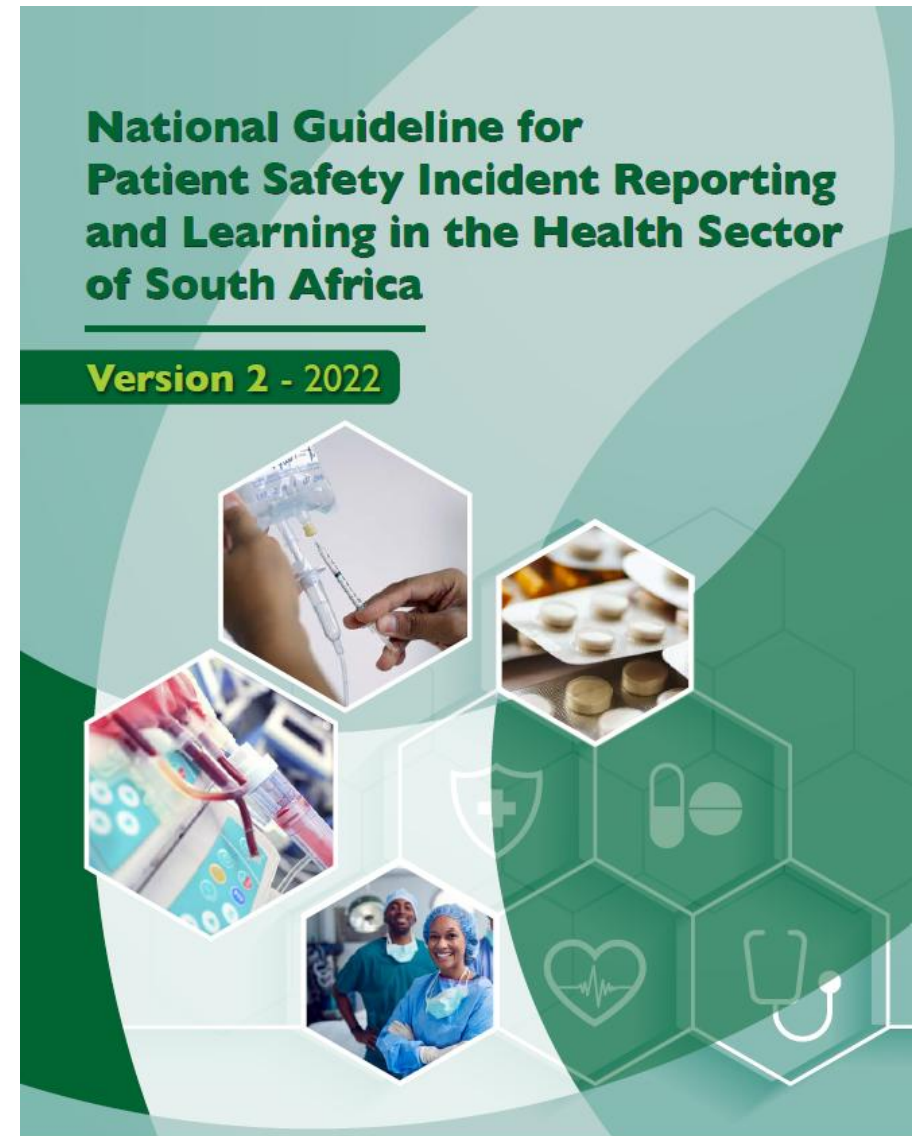
Severity Assessment Codes  
(SAC):

SAC1: Serious harm or death

SAC2: Moderate harm

SAC3: Minor harm

SAC4: No harm

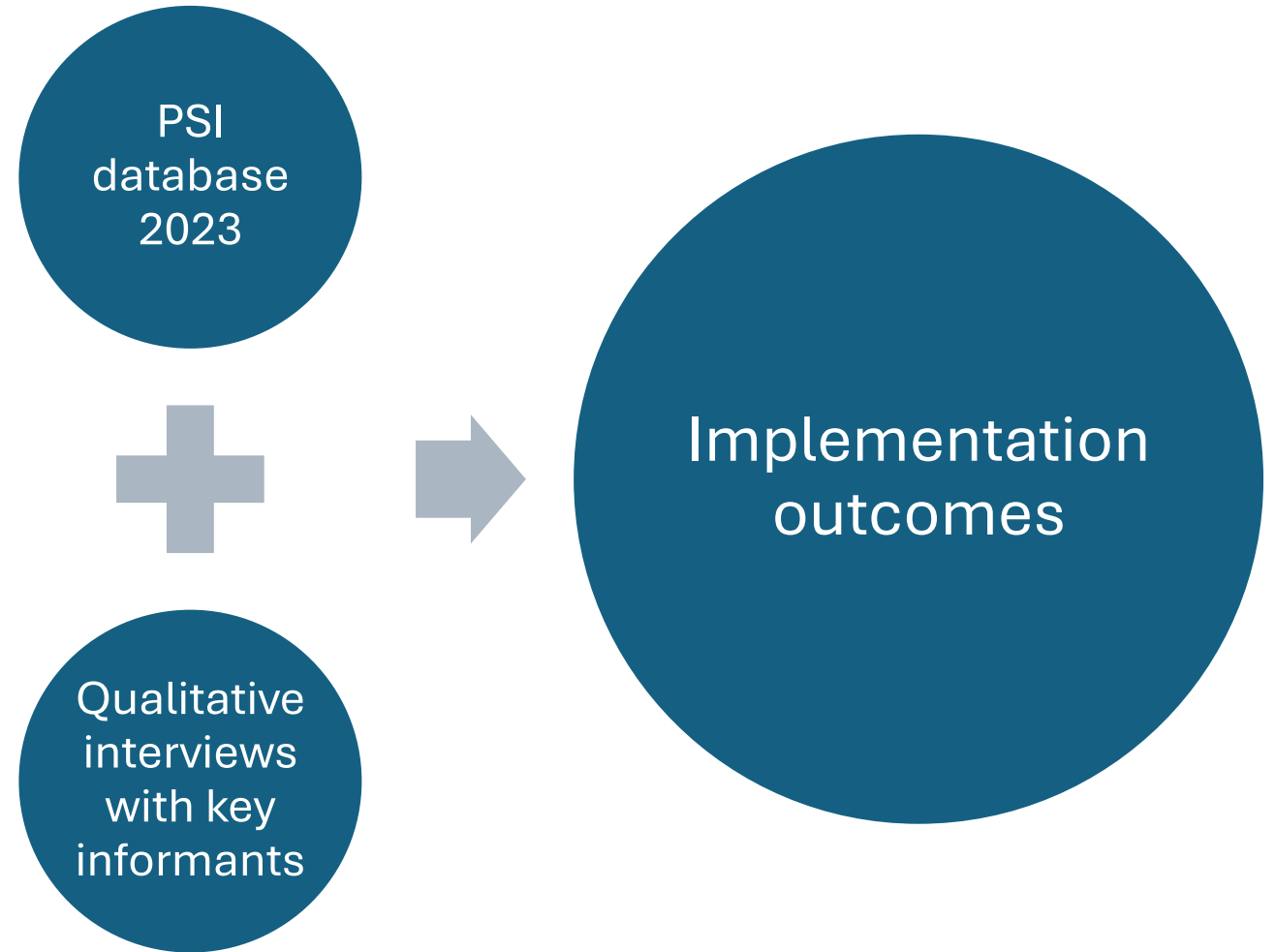


# Aim and objectives

The aim was to evaluate the implementation of PSI reporting and learning in district health services of the Western Cape.

# Methods

- Convergent mixed methods
- Implementation outcomes (RE-AIM)
- SUFPREN network of 14 district hospitals and 12 primary care facilities
- Purposeful sampling matrix
- SPSS and Framework Method



# Methods - sampling

**TABLE 1:** Characteristics of the key informants.

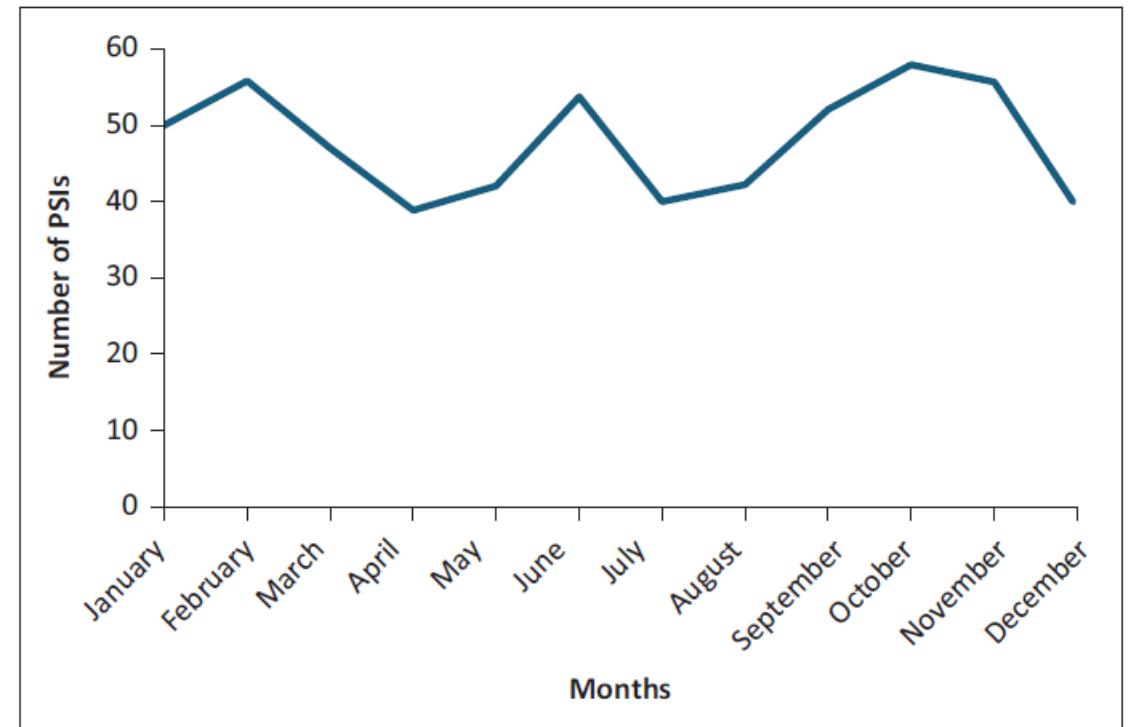
Number	Age (years)	Gender	Facility	District or substructure	Role	Years in post committee	PSI
1	43	Male	DH	CWD	Nurse manager	5.0	No
2	47	Male	DH	GRD	Family physician	3.0	No
3	45	Female	DH	CWD	Family physician	2.0	Yes
4	43	Male	DH	SWSS	Family physician	0.5	Yes
5	28	Female	PC	KESS	QA manager	2.0	Yes
6	51	Female	PC	KESS	Facility manager	9.0	Yes
7	44	Female	PC	KMPSS	Family physician	2.0	No
8	32	Female	DH	GRD	Medical officer	5.5	No
9	50	Female	DH	CWD	Facility manager	3.0	Yes
10	42	Female	DH	KESS	Medical officer	9.0	No
11	50	Female	PC	NTSS	Nurse practitioner	7.0	No
12	43	Female	PC	KESS	QA manager	2.0	Yes
13	42	Female	DH	SWSS	Family physician	5.0	Yes
14	41	Male	DH	WCD	Family physician	8.0	Yes
15	63	Female	DH	OBD	QA manager	15.0	Yes

# Results- Reach

- 16 facilities
- 577 PSIs
  - 91% district hospitals (n=10)
  - 9% primary care facilities (n=6)
- Median 19 / facility (0-148)
- Reporting levels reflects engagement with guideline and not patient safety

TABLE 2: Distribution of patient safety incidents across districts.

District	Number of facilities	PSI frequency	PSI %
Metro Health Services	9	154	26.7
Overberg	2	135	23.4
Cape Winelands	2	43	7.5
Garden Route	2	192	33.3
West Coast	1	53	9.2



# Results - Effects

## Enablers

Ammunition for change

Locus of control

Feedback staff

Feedback patients

*‘Low hanging fruit. Try to get quick wins because it also boosts morale. Just if they can say that [they] can see that something actually came from the PSI reporting. Now we’ve seen this change and it’s working. It’s helping to prepare that next PSI again.’ (Family physician, DH, MHS)*

# Results - Effects

*'The other resources, it's really difficult because we can't fill posts. So we've got two operational manager posts that are vacant, and we've got seven professional nurse posts that are vacant in the hospital. You know, so **it's very, very difficult to focus on quality and patient safety when you actually don't have nurses, you don't have managers.**' (Facility manager, DH, RHS)*

## Barriers

Austerity and budget cuts

Staffing issues

Workload pressure

Offsite repairs of equipment

Reporting vs action

# Results - Adoption

## Attitudes

Positive benefits

Bureaucracy

Punitive

Awareness

Structural variability

*‘So where we, it’s probably one of the, **it’s probably the most important meeting in our hospital.** We’ve clarified that quite a couple of times. So apart from the hospital management meeting that summarises all the other stuff, the clinical risk management meeting is very important. It probably ranks like right at the top.’  
(Family physician, DH, MHS)*

# Results - Adoption

## Attitudes

Positive benefits

Bureaucracy

Punitive

Awareness

Structural variability

*‘So, I do understand it, but it’s just irritating, and because of that, I kind of need to be nudged by someone to do it. **So I’m not overly keen to do paperwork that isn’t going to benefit me** because the work has already been done and the case is resolved and sorted out, and now I must report to somebody, and I don’t think I see the relevance at my level of reporting it.’ (Family physician, PHC, MHS)*

# Results - Adoption

## Attitudes

Positive benefits

Bureaucracy

Punitive

Awareness

Structural variability

*‘Yes. I know even at our facility, I know there have been doctors saying that **we have weaponized the patient safety incident**. They feel as if, like you mentioned, we want to target this specific person or this and in actual fact, it’s the situation that one wants to improve and yeah, and not necessarily the unfortunate nurse that did it.’  
(Medical officer, DH, RHS)*

# Results - Adoption

## Attitudes

Positive benefits

Bureaucracy

Punitive

Awareness

Structural variability

*'Umm, I've browsed through them.'* (QA manager, SS, MHS)

# Results - Adoption

## Attitudes

Positive benefits

Bureaucracy

Punitive

Awareness

Structural variability

*'I am the chairperson of the forum. The other three specialists [are the] head of nursing, the different operational managers [or] nursing managers in their areas, [and] we have the quality assurance manager. The quality assurance manager actually deals with a whole host of things. So under her portfolio there is infection prevention control the OSS, ideal hospital, dealing with complaints, risk management and PSI ... **The only person we don't have is a hospital board member**, which is a requirement from the national guidance as well.'* (Family physician, DH, MHS)

# Results – Implementation

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## SAC score

SAC1	103	17.9
SAC2	143	24.8
SAC3	188	32.6
SAC4	142	24.7

## Main class of PSI

Patient behaviour	136	23.6
Patient accident or fall	120	20.8
Medication or IV fluids	100	17.4
Clinical processes	85	14.8
Nosocomial infection	23	4.0
Clinical administration	18	3.1
Staff behaviour	10	1.7
Infrastructure	9	1.6
Medical equipment	9	1.6
Other	60	10.4

# District hospitals and psychiatric patients

*‘There was actually a patient that **burned the whole ward down** just in the time that I was there and almost burned a non-psych patient.’ (Family physician, DH, RHS)*

*‘So our most famous one was when two teenagers had sex in the mental health ward, **and it was a statutory rape**. So that was our biggest patient safety incident in my time.’ (Facility manager, DH, RHS)*

# Results - Sustainability

## Strategies

Training

Organisational culture

QA managers

Adaptation for primary care

*‘So initially I found myself very, very, yeah, unequipped. But the knowledge hub came up with this training online and I did it initially at first and then I taught my team through it and then **I actually had it mandated by our hospital manager to include it in all the PAs of the managers in the hospital.**’ (Family physician, DH, MHS)*

# Conclusions - implications

- Train all managers and family physicians in the PSIRLS
- Inform all clinical staff via CPD and induction, with feedback
- Improve infrastructure for psychiatric patients
- Expenditure on equipment < expenditure on harm
- Re-appoint QA managers
- Adapt system more to primary care context
- Patient or community participation