National Guideline for Patient Safety Incident Reporting and Learning

Ideal Clinic Realisation and Maintenance Programme

Directorate: Quality Assurance
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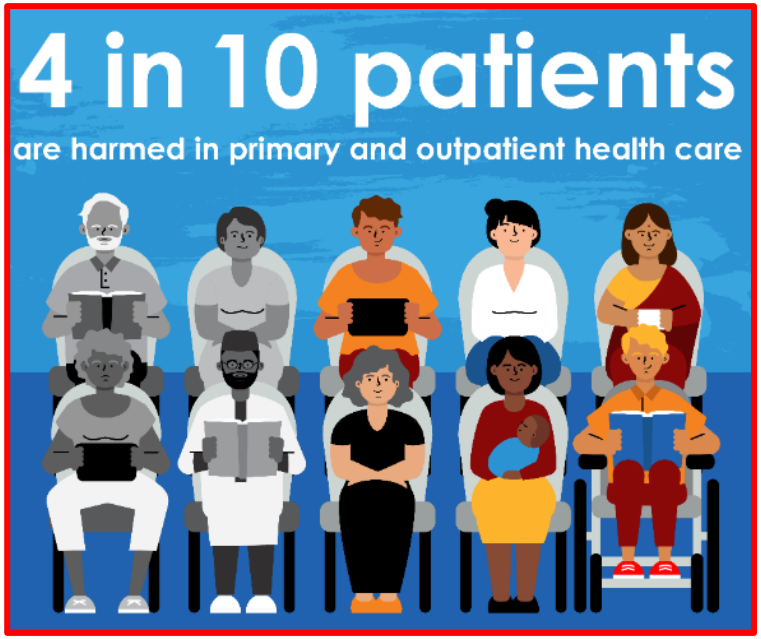
Patient Safety

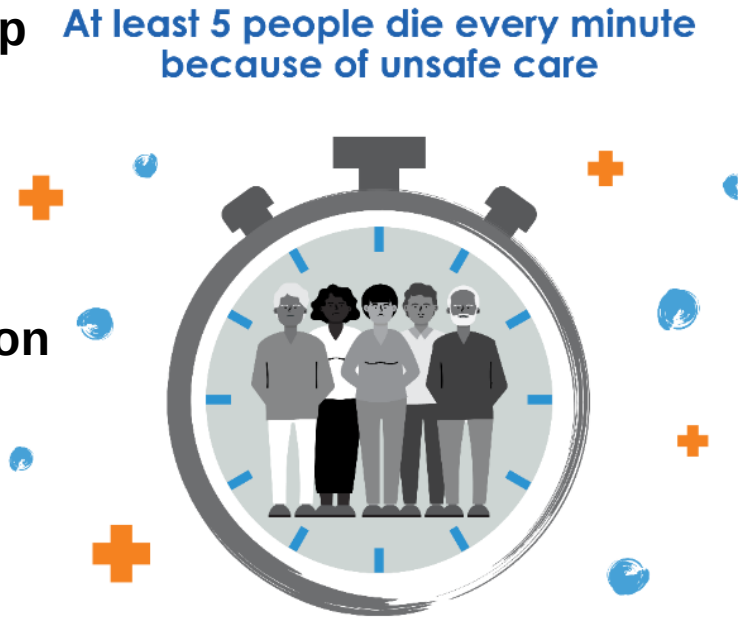
Why is patient harm a global priority?

Patient harm due to adverse events is one of the **top 10 causes of death and disability** in the world.

High-income countries - about **1 in 10 patients are harmed** while receiving hospital care.

Low and middle-income countries - about **134 million adverse events occur annually** in hospitals, contributing to 2.6 million deaths every year.





15% of total hospital expenditure is a direct result of harmful incidents

Purpose of the Guideline

- Provide direction to the public health sector of South Africa regarding the **management of Patient Safety Incident (PSI) reporting**,
- Give guidance on **appropriate feedback** to patients, families/support persons and clinicians, and
- **Share lessons learned** to **prevent reoccurrence of patient harm.**

Mandatory requirements according to Regulations

All health facilities must have a system in place to manage PSIs* according to the following principles:

- Confidential
- Timely
- Just Culture
- Responsive
- Openness about failures
- Emphasis on learning

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*** Norms and Standards Regulations applicable to different categories of health establishments (2018)**

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Definition of PSI

A 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 due to the underlying health condition or natural progression of disease.

PSI can be a near miss, no harm incident or harmful incident (adverse event).

Event occurred

And if the event does reach the patient but the patient is unharmed?

Yes!

Event occurred whilst the patient was in the care of health facilities

Event resulting from the delivery of care or event occurred while patient was receiving care

Report as a patient safety incident

What happens if there is an event, but it did not reach the patient – do I still report it as a PSI?

Yes!

No harm incident: A no harm incident is an incident which reached a patient, but no discernible harm resulted.

Incident reaches patient

Incident does not reach patient

No harm incident

Near miss

Near miss: A near miss is an incident which does not reach the patient

Event occurred

Yes, if the harm is as a result of incorrect medical management or failure of the health service provided

Event occurred whilst the patient was in the care of DOH facilities

And then, any incident which results in harm to the patient?

Event resulting from the delivery of care or event occurred while patient was receiving care

Harmful incident (adverse event): is an incident that results in harm to a patient that is related to medical management, in contrast to disease complications or underlying disease.

Report as a patient safety incident

Incident reaches patient

Incident does not reach patient

No harm incident

Harmful incident

Near miss

What is reported?

- PSIs include: Harmful incidents, no harm incidents and near misses

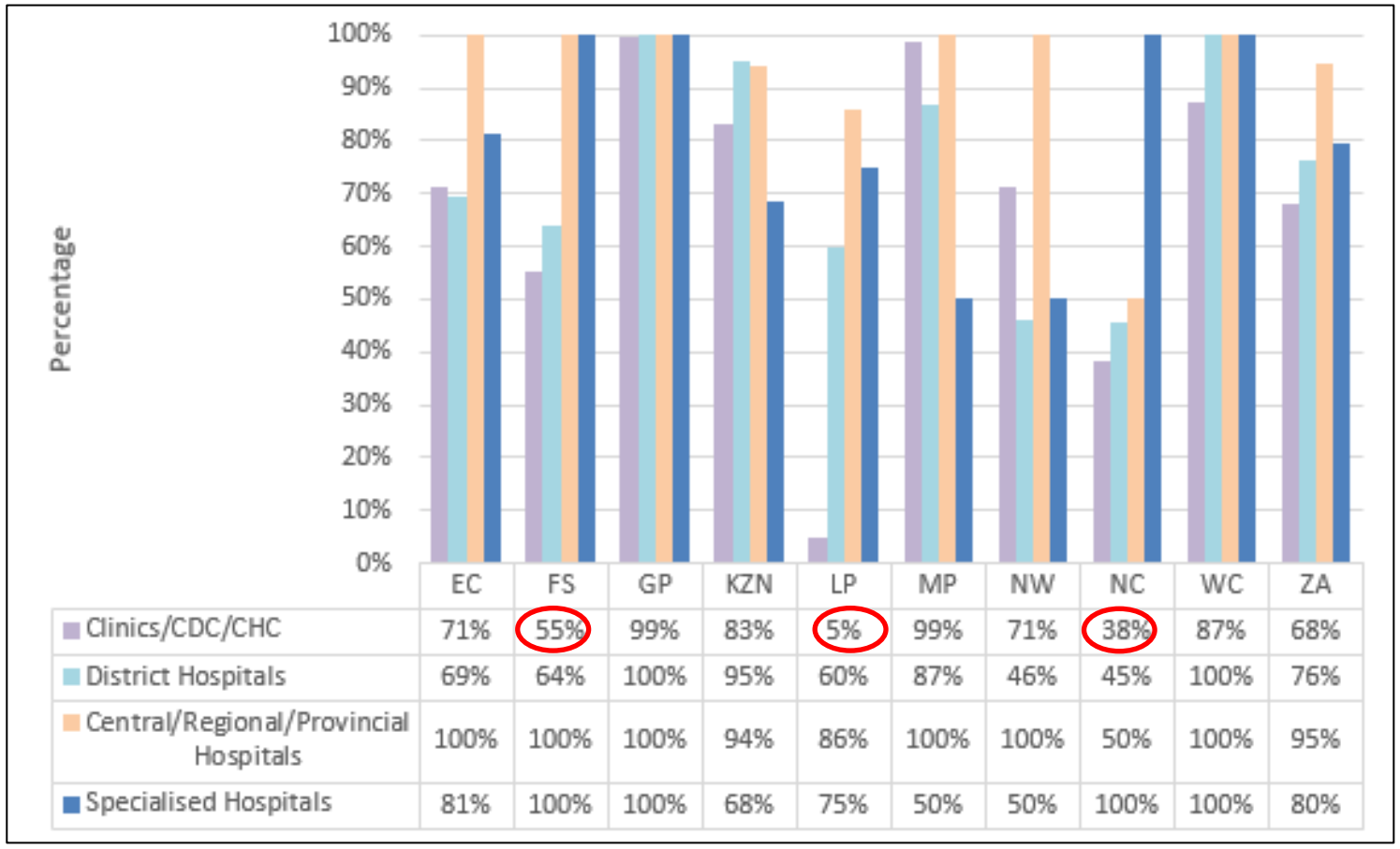
- WHO's Minimum Information Model (MIM) is used for PSI reporting. Information is classification according to:
  - ✓ Incident identification (patient (age & sex), time, location)
  - ✓ Contributing factor*
  - ✓ Incident type*
  - ✓ Incident outcomes (patient & organization)*
  - ✓ Resulting actions
  - ✓ Reporter
  - ✓ Free text (Summary of PSI & Findings/ recommendations)

* WHO Conceptual framework for the international classification for patient safety

Ideal Clinic Elements Performance 2023/24

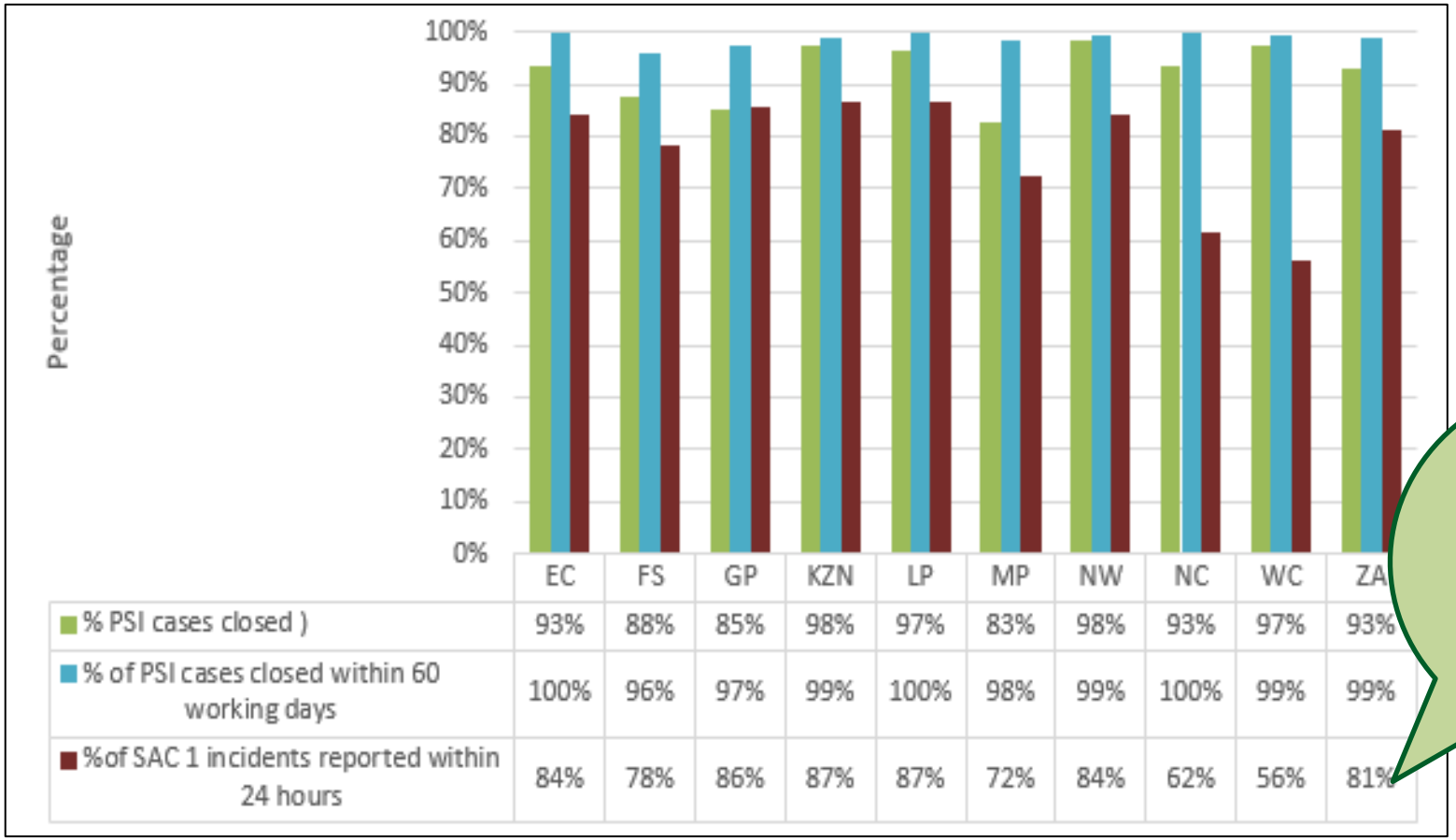
		Eastern Cape	Free State	Gauteng	KwaZulu-Natal	Limpopo	Mpumalanga	North West	Northern Cape	Western Cape	Overall %
Element	Weight										
Clinical guidelines and protocols		91%	95%	98%	93%	88%	97%	97%	82%	97%	93%
National Guideline for Patient Safety Incident Reporting and Learning is available	E	98%	98%	99%	97%	97%	98%	99%	95%	100%	98%
Facility/district SOP for Patient Safety Incident Reporting and Learning is available	E	95%	95%	99%	95%	85%	98%	100%	72%	94%	94%
Patient safety incident records comply with the National Guideline for Patient Safety Incident Reporting and Learning	V	85%	92%	98%	89%	83%	96%	94%	73%	95%	89%
All SAC 1 adverse events are reported to the next level of management within 24 hours	V	83%	94%	95%	90%	85%	95%	95%	90%	98%	89%

Results Annual Report 2022/23
Compliance Rate



	EC	FS	GP	KZN	LP	MP	NW	NC	WC	ZA
Clinics/CDC/CHC	71%	55%	99%	83%	5%	99%	71%	38%	87%	68%
District Hospitals	69%	64%	100%	95%	60%	87%	46%	45%	100%	76%
Central/Regional/Provincial Hospitals	100%	100%	100%	94%	86%	100%	100%	50%	100%	95%
Specialised Hospitals	81%	100%	100%	68%	75%	50%	50%	100%	100%	80%

PSI Indicators



	EC	FS	GP	KZN	LP	MP	NW	NC	WC	ZA
% PSI cases closed)	93%	88%	85%	98%	97%	83%	98%	93%	97%	93%
% of PSI cases closed within 60 working days	100%	96%	97%	99%	100%	98%	99%	100%	99%	99%
%of SAC 1 incidents reported within 24 hours	84%	78%	86%	87%	87%	72%	84%	62%	56%	81%

New Functionality PSI Notification Report

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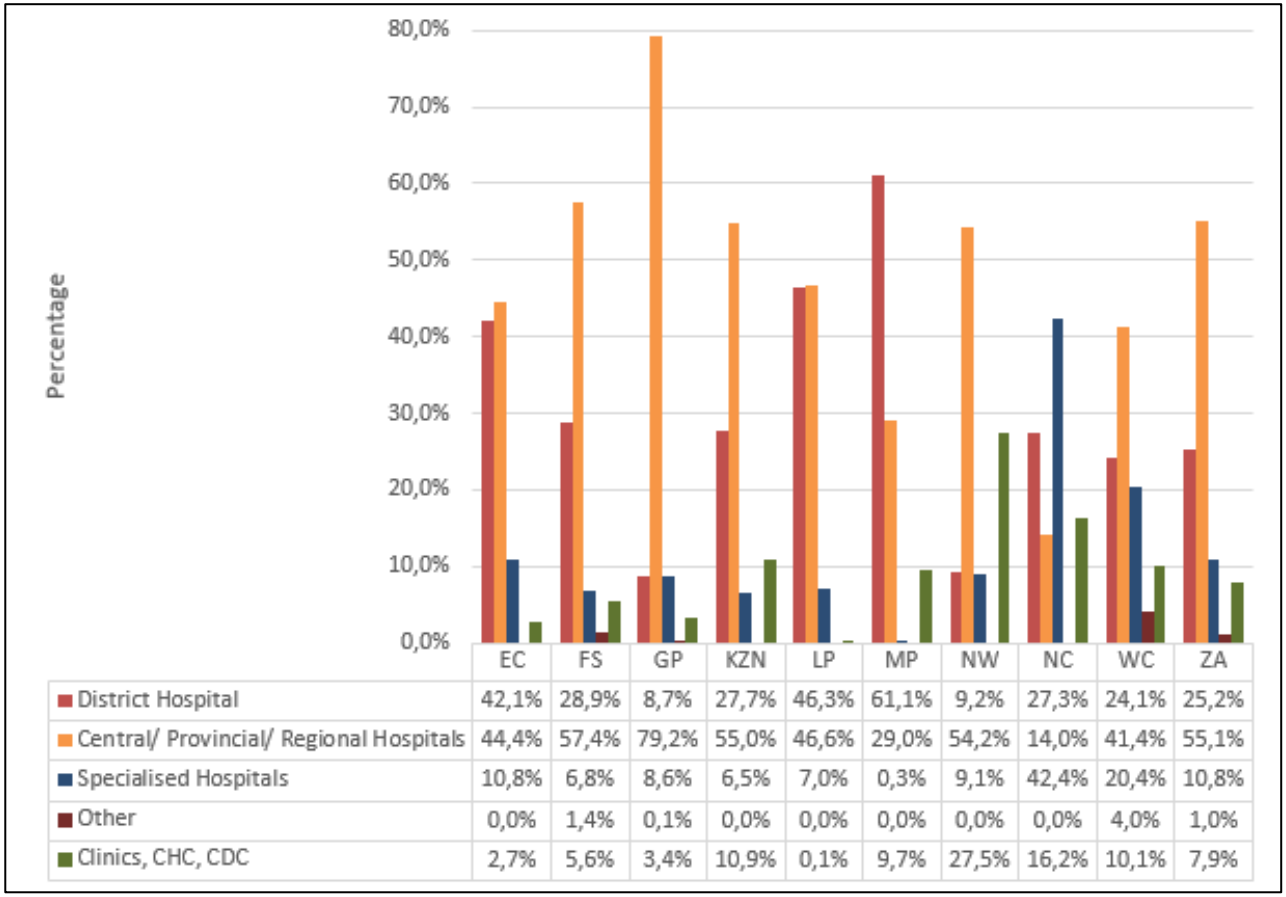
Percentage of PSIs reported by level of care

Number of hospitals: 385

Number of PHC facilities: **3473**

- **A total of 2 335 PSIs reported for 2022/23 On average a PHC facility reported less than 1 PSI annually??**
- **Vs Global data: 4 in 10 patients are harmed in primary care**



	EC	FS	GP	KZN	LP	MP	NW	NC	WC	ZA
District Hospital	42,1%	28,9%	8,7%	27,7%	46,3%	61,1%	9,2%	27,3%	24,1%	25,2%
Central/ Provincial/ Regional Hospitals	44,4%	57,4%	79,2%	55,0%	46,6%	29,0%	54,2%	14,0%	41,4%	55,1%
Specialised Hospitals	10,8%	6,8%	8,6%	6,5%	7,0%	0,3%	9,1%	42,4%	20,4%	10,8%
Other	0,0%	1,4%	0,1%	0,0%	0,0%	0,0%	0,0%	0,0%	4,0%	1,0%
Clinics, CHC, CDC	2,7%	5,6%	3,4%	10,9%	0,1%	9,7%	27,5%	16,2%	10,1%	7,9%

Online Training Course for Patient Safety Incident Reporting

Four training modules: https://knowledgehub.health.gov.za

KnowledgeHub
Your Professional Development Platform

1

- Introduction and general overview

2

- Management of PSIs
  - ✓ Part 1 - Step 1 to 5
  - ✓ Part 2 - Step 6 to 9

3

- PSI Classification examples and explanations
  - ✓ Part 1 - Incident type
  - ✓ Part 2 - Contributing factors and Outcomes

4

- Implementation, reporting and learning

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END

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