Assisting health workers to deliver safe patient care

PatSIS®

Incident Reporting, Monitoring and Management System

A multidisciplinary solution to adverse events....

- ✓ Reduce litigation
- ✓ Improve patient safety and quality of care
- ✓ Increase patient satisfaction
- ✓ Reduce number of complaints
- ✓ Boost staff morale

THE PROBLEM

Every day, thousands of errors occur in healthcare systems around the world. The severity and magnitude of these errors was unknown until 1999 when the Institute of Medicine in the United States released the report, *"To Err is Human – Building a Safer Health Care system"*[1].

Using Centers for Disease Control and Prevention statistics, the report estimated that between 44000 and 98000 people were dying each year in the U.S. as a result of medical errors, which exceeded the annual number of deaths from motor vehicle accidents (43,458), breast cancer (42,297) or AIDS (16,516).[2]

Fortunately, most errors do not result in adverse events, but those that do exact a sizeable toll in injury, disability and death. The reporting and monitoring of adverse events and near misses can contribute to a high level of risk awareness in healthcare facilities and lead to pro-active system changes to decrease the probability of errors occurring.

INTERNATIONAL ACTION

In October 2004 the World Health Organisation launched a global patient safety programme, WHO Patient Safety, designed to coordinate and accelerate improvements in patient care of member countries and disseminate learning to prevent unnecessary harm to patients.[3] COHSASA was privileged to collaborate in the initial development of this programme and since then has continued to gain experience in this field in South Africa.

WHAT IS PatSIS?

PatSIS consists of two elements: a computer programme used to record information regarding adverse events and near misses and a call centre operated by professional healthcare staff to collect data on the incidents. PatSIS offers an alternative to the time-consuming, paper-based process currently used in many health facilities.

Information regarding incidents is gathered by means of incident-specific cascading questions. Once all information is entered into the database, an email notification is sent to nominated relevant staff members at the health facility to initiate an investigation into the incident.

When a serious adverse event (e.g. death) is reported, nominated senior staff and management at the facility are alerted by means of email and SMS.

Email reminders are sent at pre-determined intervals until an investigation is completed and recorded in PatSIS along with the preventive measures planned to prevent recurrence. These entries are then reviewed by PatSIS staff trained in adverse event management. Any inadequacies in investigation or response are reported to facility staff and guidance given on additional actions required to prevent recurrence.

Recorded data is then available for analysis at individual facility level or across facilities in a region or province.

ORIGIN OF PatSIS

In 2008, the Australian Advanced Incident Management System (AIMS), conceptualised by Professor Bill Runciman, President of the Australian Patient Safety Foundation, was implemented in the Free State Province in 24 facilities. The programme demonstrated tangible benefits and additional facilities were enrolled over time.

In 2012 the system attracted the attention of the Department of Public Services Administration and was entered into the Centre for Public Service Innovation Awards achieving second runner-up position.

AIMS was discontinued in 2013 and COHSASA developed PatSIS to replace AIMS, designing the new programme specifically for conditions in developing countries.

APPROACH

To maximise the benefit offered by PatSIS, all healthcare workers are encouraged to report any incident that caused harm or might have caused harm to a patient. Investigation into such incidents should focus on learning lessons from adverse events and near misses, which can then inform the design and implementation of processes to reduce the likelihood of recurrence of the incident, or minimise harm should the incident recur.

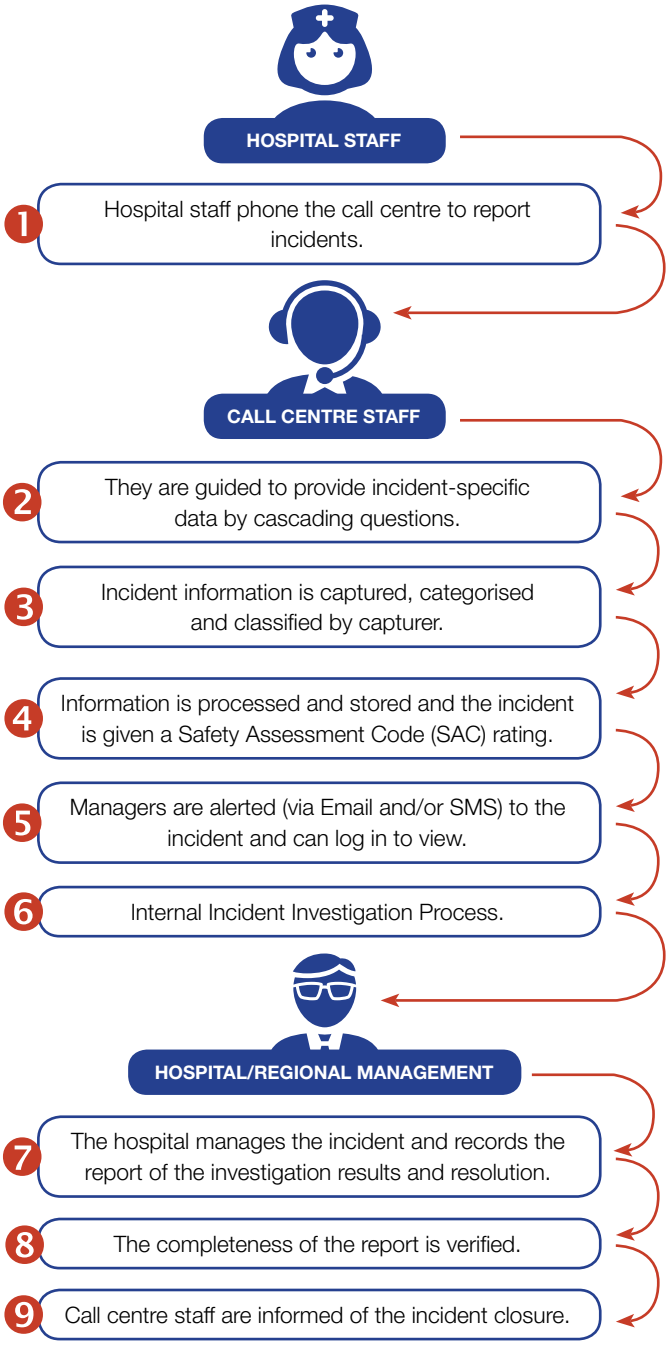
The focus is thus on reporting and investigation rather than apportioning blame to individuals involved, recognising that the complexity of healthcare today means that patient outcomes depend on far more than the competence of an individual health care provider.[4]

This approach promotes an environment conducive to learning from the inevitable errors that occur in the delivery of healthcare services. It encourages participation in the process for the benefit of future

service delivery, rather than avoidance of the process due to fear of retribution. However, it does not condone or offer amnesty for reckless or criminal behaviour should this be identified during the investigation process. This approach is called a “Just Culture”.

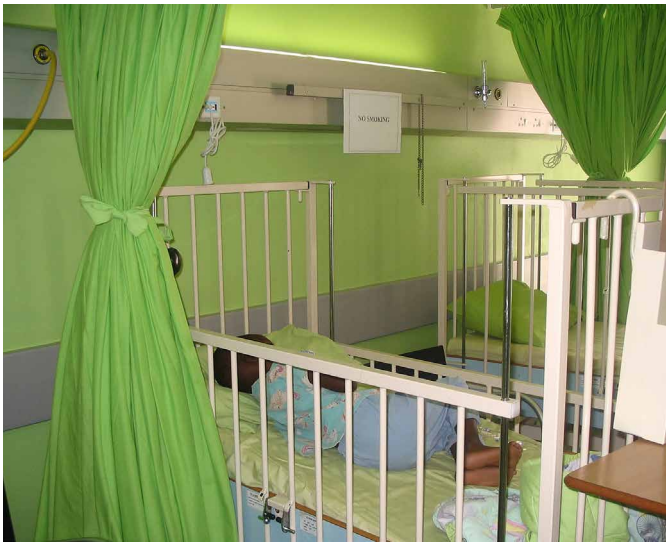
REPORTING AN INCIDENT

Incidents can be reported by clinical or non-clinical staff members who have been involved in or have witnessed the event. The reporting individual contacts the call centre and the details of the incident are collected by trained health professional staff who record the information directly into the database.



DASHBOARDS

Within PatSIS tasks can be assigned to designated staff members or departments and the completion of these tasks is tracked over time. Incident management is facilitated by a dashboard of indicators which can be customised to suit client preferences. Reports are available in PDF, MS-word or MS-Excel formats. PatSIS can be accessed by means of a Smart Phone, a tablet, a desktop computer or a laptop.



CONFIDENTIALITY AND SECURITY

PatSIS is a secure, web-based system. Each user has a unique, encrypted username and password with an associated access level appropriate to their level of responsibility. This ensures that hospital managers can only see the data for their own hospitals, whereas regional managers can see the data for all facilities under their control.

BENEFITS

- Manage negative incidents effectively
- Unique identifier (case number) allocated to each incident reported
- Trained professional staff capture, date and classify incidents
- Objective, systematic analysis of each incident
- Any staff member can call to report an incident
- Anonymous reporting if preferred
- Call duration usually 7 minutes or less
- Only Internet access required; no specific IT

REFERENCES

1 “To Err is Human, Building a Safer Health System. Linda T Kohn, Janet M Corrigan and Molla S Donaldson, Editors. Committee on Quality of Health Care in America; Institute of Medicine, National Academy Press, Washington DC. 1999.
2 Centers for Disease Control and Prevention (National Center for Health Statistics). Births and Deaths: Preliminary Data for 1998. National Vital Statistics Reports. 47(25):6, 1999.
3 http://www.who.int/patientsafety/about/en/
4 http://www.who.int/patientsafety/information_centre/documents/who_ps_curriculum_summary.pdf page 3.

FURTHER INFORMATION

Please contact the PatSIS call centre at 021 5314226/7

patsisinfo@cohsasa.co.za

www.cohsasa.co.za

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