THE REPUBLIC OF UGANDA

MINISTRY OF HEALTH

Health Facility Patient Safety Report Handbook

Enhancing Documentation, Reporting and Action on Incidents and Near Misses in Health Service Delivery

December 2025

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Acronyms

5S	Sort, Set, Shine, Standardize, Sustain
CQI	Continuous Quality Improvement
DHT	District Health Team
HPSR	Health Facility Patient Safety Report
HFQAP	Health Facility Quality Assurance Program
MoH	Ministry of Health
PHD	Public Health Department
PSFP	Patient Safety Focal Person
QI	Quality Improvement
QIT	Quality Improvement Team
RRH	Regional Referral Hospital
SCAPP-D	Standards, Compliance, Accreditation and Patient Protection Department
TQM	Total Quality Management
WEI	Work Environment Improvement
WIT	Work Improvement Team

Preface

Patient safety is a crucially important topic for any type of health service that must pursue "patient-centered healthcare". Health Facility Patient Safety Report (HPSR) is a newly introduced term in Uganda, equivalent to what is widely known in other countries as an "Incident Report" or an "Occurrence Variance Report". This appellation, represented by HPSR, was deliberately given to this important in-health facility activity, which involves documenting and reporting near misses and incidents related to both clinical and non-clinical setting in order to take action to address gaps in the national health system. The reason for this naming is to create a positive image and minimise the negative ones which cause self-restriction in reporting unfavourable events, with a sense of blaming the engaged personnel including the reporters themselves to their own division, typically to the Quality Improvement Team (QIT), which is supposed to handle analysis, countermeasure promotion, and feedback to the actual venues, where the events occurred.

The term "incidents", in our context of healthcare, was defined as "any deviation from usual care that either causes an injury to the patient or poses a risk of harm, including errors, preventable adverse events and hazards" (WHO, 2020).

In this guidance booklet for HPSR, highlights are given to (1) full participation of health facility staff regardless of the category and rank, (2) improvement of staff's sensitivity and specificity in reporting near misses, which are defined as a part of incidents without actual harm to the patients, and (3) the linkage of the HPSR practice and KAIZEN implementation for uplifting patient safety.

Teamwork of multi-disciplinary staff in healthcare institutes is often discussed as the absolute need for realizing patient-centered healthcare. We are, at the same time, suffering from a chronic shortage of medical staff particularly of nursing cadre as often reported from other countries. The above-mentioned patient-centered care is not easy to realise if only two nursing officers must, for example, take care of 40-50 patients in a ward in a daytime shift.

Even under the said difficulties, medical staff in government sector health facilities in Uganda always work hard to cope with the patients' needs. Sending HPSR messages to QIT could be seemingly a burden for the staff, who are extremely busy with routine work. If you once become familiar with the concept and practice of this reporting scheme, however, you will be capable of handling the job timely and quickly with an understanding of the distinctive effectiveness of HPSR, which can create opportunities for KAIZEN implementation influential to the problem-solving for uplifting both patient safety and quality of care.

Dr. Charles Olaro
Director General Health Services
Ministry of Health

Acknowledgement

On behalf of the Ministry of Health of the Republic of Uganda, I would like to express my profound gratitude to all individuals and institutions whose invaluable contributions and unwavering dedication have made the development of this Health Facility Patient Safety Practice Report (HPSR) Handbook possible. The MoH Directorate of Governance and Regulation through the Department of Standards, Compliance, Accreditation and Patient Protection has taken the lead in developing and finalizing this publication. The leadership and the entire membership involved is greatly appreciated for the highly resourceful input provided for this work to be accomplished.

This handbook represents a significant milestone in our ongoing efforts to ensure patient safety and establish sustainable, high-quality health facility services across our nation. By outlining a structured approach to incident and near-miss reporting and management, this handbook provides a critical framework for fostering a strong safety culture throughout all levels of healthcare delivery.

I wish to extend special appreciation to our national stakeholders as well as to the Government of Japan and Japan International Cooperation Agency (JICA) for their outstanding technical assistance under the Project for the Establishment of Patient Safety through 5S-CQI (KAIZEN)-TQM. Their expertise and partnership have ensured that this handbook aligns with both global standards and local realities, making it practical, actionable, and contextually relevant for Ugandan health facilities.

It is our sincere hope that this handbook shall serve not merely as a reference, but as a tool for transformative practice—encouraging participation from all healthcare personnel, irrespective of role or rank, in the collective pursuit of safer healthcare systems.

The Ministry of Health remains firmly committed to supporting the effective implementation of this handbook, including the necessary institutional arrangements, human resource development, and continuous quality improvement measures. We will continue to work toward building a healthcare system that upholds patient safety as a core value and ensures the health and well-being of every Ugandan.

In conclusion, I wish to once again express my heartfelt appreciation to all contributors involved in this important endeavor. I look forward with great anticipation to the meaningful impact this handbook has in promoting a culture of patient safety and excellence in healthcare nationwide.

Dr. Joseph Okware
Director Health Services (Governance & Regulation)
Ministry of Health

1 Introduction

What should we strive for to make our health facility better and safer?
The ethical principle of "do no harm" means that any action taken should not harm the patient. However, events may occur that result in unexpected outcomes.

This handbook helps to enhance the safety of our facility and become a "High Reliable Organization (HRO)" by establishing a safety culture. The term "safety culture" was first coined in the International Nuclear Safety Group's 1986 summary report following the Chernobyl nuclear accident, and to put it simply, safety culture refers to an assembly of attitudes and values that prioritize no harm in an organization. According to Prof. James Reason, a psychologist known as a human factor safety specialist, a safety culture could be equated to an informed culture, where those who manage and operate the system have up-to-date knowledge of the human, technical, organizational, and environmental factors that determine the overall safety of the system. He also propounded that the safety culture comprises four subcultures: Reporting culture, Just culture, Flexible culture, and Learning culture. These subcultures are illustrated in Figure 1.

Figure 1: Four components of safety culture

Why do harmful events occur in our health facilities?

The absence or insufficiency of a "Safety Culture" is the most important cause of the harmful events that we shall now refer to as incidents.
"Patient safety culture" for health facilities is focused on the aspects of organisational culture that relate to patient safety. It is defined as a pattern of individual and organisational behaviour, based upon shared beliefs and values that continuously seek to minimise patient harm, which may result from the process of care delivery. Considering the above definition, the rules and regulations on patient safety are the foundations of safe and quality services at every clinical venue. If those foundations are not established or, even if existing, are not respected by staff, patients, and other stakeholders, patient safety during the patient journey in the process of diagnosis, treatment, and prognosis observation cannot be guaranteed.

Government health facilities in developing countries face intrinsic obstructive factors hindering their improvement in patient safety. We can identify the factors that need to be addressed if we listen humbly to our own voices from heart and mind for reviewing our health facility's "Safety Culture." While the challenges are numerous, they can be categorized into several key areas:

1. Resource Limitations

Inadequate Infrastructure:

Many health facilities struggle with insufficient facilities, such as a lack of proper sanitation, water supply, and adequate patient transport systems. This leads to unsafe conditions that compromise patient care.

Staffing Shortages:

High workloads due to insufficient staffing ratios result in healthcare professionals being overburdened, which negatively impacts their ability to provide safe care.

2. Communication Barriers

Poor Information Flow:

Ineffective communication among healthcare staff hampers the transfer of critical information, leading to misunderstandings and errors in patient care.

Fear of Reporting Errors:

A culture of blame discourages health workers from reporting mistakes or adverse events, preventing learning and improvement from these incidents.

3. Lack of Management Support

Weak Governance:

Inadequate leadership and governance structures fail to enforce safety protocols and standards, which are essential for fostering a safety culture. Poor governance is often cited as a root cause of systemic flaws within healthcare settings.

4. Insufficient Training and Development

Limited Professional Development Opportunities:

A lack of training for healthcare professionals results in gaps in knowledge and skills necessary for maintaining patient safety. This is compounded by the absence of clear patient safety guidelines and protocols that would help standardize care practices.

5. Cultural Factors

Blame Culture:

The prevailing attitude towards medical errors often involves blaming individuals rather than addressing systemic flaws, which stifles open communication about safety concerns and hinders improvement efforts.

Why do we need the HPSR Handbook?

"A near miss reported today is an accident that will not happen tomorrow." We always learn from what went wrong and work proactively to prevent major events. To ensure optimal learning, therefore, all healthcare professionals need to report and share unfavourable events as soon as they become aware of them, even if those events or phenomena may seem insignificant. That is why we have the HPSR system.

This handbook intends to motivate, facilitate, and aid health facility staff in observing the patients/visitors at all work areas, detecting problems and risks, and writing the HPSR forms in a precise and efficient manner. It provides a concise overview of the incident management process and its underlying principles to healthcare personnel and helps them respond appropriately to any potential incidents that may occur in their workplaces.

Who are the intended users of the HPSR Handbook?

The principles in this handbook can be applied to all categories of health facilities which are delivering clinical services to patients in Uganda. This handbook applies to both clinical staff and non-clinical staff. Patient Safety Focal Persons (PSFPs), assigned to clinical venues, are expected to lead the intra-organizational movement of HPSR use. The activities should be participatory by the entire personnel. All individuals serving in health facilities are reporters of near misses and incidents.

2 Definition and classification of incidents

What is the definition of an incident?

Healthcare incidents are unfavourable events that harm or have the potential to harm a patient, attendant, or other individuals - for example, a medical error, patient injury, or equipment failure. The term “incidents”, in the context of medical care, is defined as “any deviation from usual medical care that either causes an injury to the patient or poses a risk of harm, including errors, preventable adverse events and hazards” (WHO, 2020).

How are incidents classified?

Patient safety incidents are classified into three categories: near miss, no harm incident, and harmful incident. (2020, WHO)

1. Near miss: An incident that did not reach the patient.

Imagine a situation where a unit of blood being connected to the wrong patient’s intravenous (IV) line, but the error was detected before the transfusion was commenced. This should be called a near miss.

A visitor to a ward was walking on a wet floor in a corridor and about to fall, but, fortunately, the visitor could avoid the fall by holding onto a nearby handrail. This is also a near miss.

2. No harm incident: An incident in which an event reached a patient, but no discernible harm resulted.

Imagine a situation where a unit of blood was transfused to the wrong patient but was not incompatible. This could be reported as a no harm incident.

A visitor to a ward fell, but coincidentally he leaned on a passer-by who promptly offered support, preventing him from sustaining any injuries. If this was observed by a staff, it should be reported as no harm incident.

3. Harmful incident: An incident that results in harm to a patient.

Imagine a situation where the wrong unit of blood was transfused, and the patient died from haemolytic reaction or suffered a severe rash with difficulty breathing. These are serious cases of a harmful incident.

A visitor to a ward slipped on a wet floor in the corridor and he suffered a serious sprain on his ankle. While this injury itself is not caused by medical issues, it is a consequence of the unsafe physical environment within the health facility, and this should be regarded as a harmful incident.

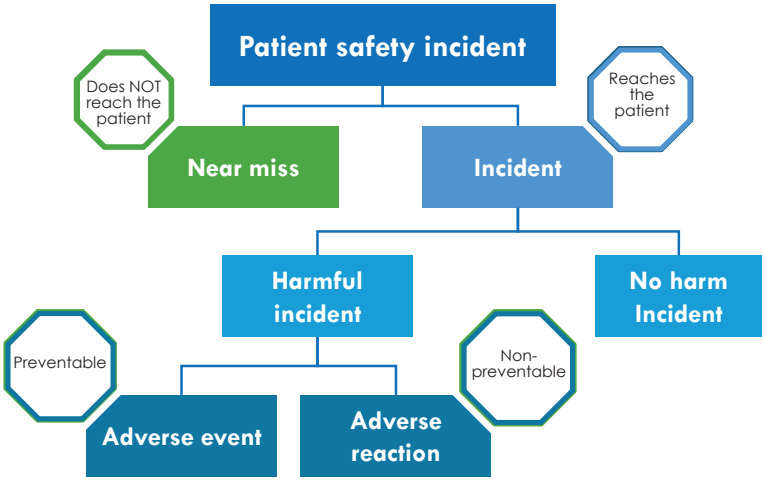
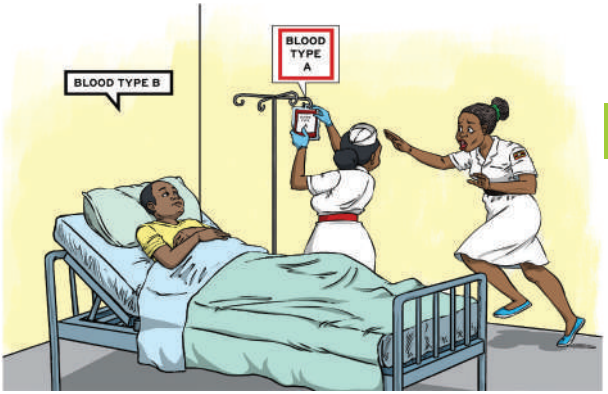


Figure 2: Classification of incidents

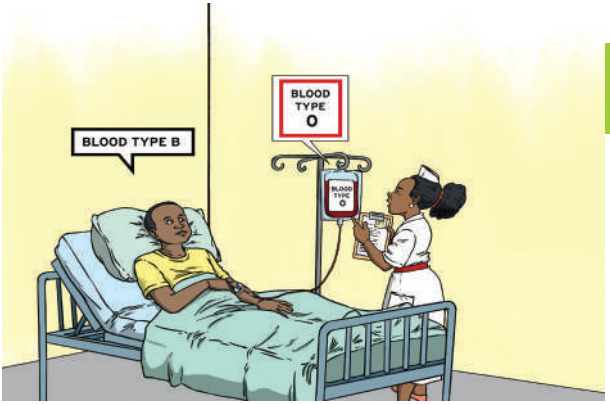
"Adverse Event (AE)" and "Adverse Reaction (AR)" as the results of harmful incidents should herewith be defined to distinguish the two clearly. AE is an incident that results in preventable harm to a patient, whereas AR is defined as non-preventable harm resulting from a justified action where the correct process is followed for the context in which the incident occurred.

The distinction between AE and AR was highlighted in clinical pharmacy. An Adverse Drug Event (ADE) is harm caused by appropriate or inappropriate use of a drug, whereas Adverse Drug Reactions (ADRs) are a subset of these events, where harm is directly caused by a drug under appropriate use (i.e., at normal dose). ADEs may include cases of provider error, non-adherence, or incorrect dosages. (Nebeker, Barach, and Samere, 2004)



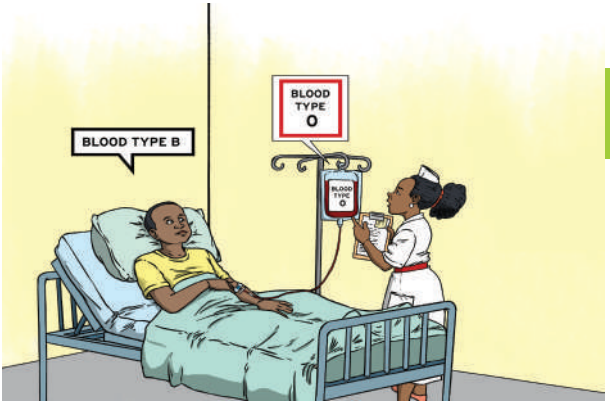
Near miss

An error was detected before the wrong unit of blood was administered to a patient.



No harm incident

A unit of blood was transfused to the wrong patient, but was not incompatible.



Harmful incident

The wrong unit of blood was transfused, causing severe or fatal hemolytic reactions.

Figure 3: Example of near misses, no harm incident, and harmful incident in blood transfusion

3 Principles of Incident Management

Incident management is defined as the set of activities initiated in response to an incident to mitigate immediate risks, investigate the incident, identify contributing factors, and recommend measures to prevent recurrence. Incidents managed under the principles outlined below are more likely to be resolved with an acceptable outcome for all involved and will reduce the risk of similar incidents occurring in the future.

Make HPSR our culture

Health facilities create an atmosphere where the staff, patients, attendants, and families feel safe to report safety concerns without fear or blame. During an incident investigation, health facilities will treat everyone fairly, according to Just culture, using a systems-based approach.

Encourage open and honest reporting

Under the principle of just culture, incident investigations focus on system-level factors rather than individual blame. Staff are treated fairly, and disciplinary or criminal actions are only considered in rare cases of gross negligence or intentional misconduct. Frequent and honest reporting is encouraged and valued. Such reporting helps improve care quality, promotes learning, and strengthens a transparent and high-reliability safety culture.

Keep the timeliness of action

Health facilities have a duty to take reasonable care to avoid harm to patients, staff, contractors, and visitors. When a patient is harmed, health facilities will undertake an investigation and take actions to remedy problems in a timely manner.

Prioritize problem-solving

Health facilities prioritize actions to address problems and direct resources to the areas of highest clinical risk and where the greatest

improvements are possible.

Learn lessons from near-misses and incidents

The reporting system is oriented toward learning from near misses and incidents across the health sector to prevent further patient harm and to take collective remedial action.

- Open and transparent communication between the patient and health workers. In case an event occurs and results in harm, the health worker should communicate clearly with the patient about the harm and any other possible reactions that may result. This helps to alleviate fear and the blame game.
- Documentation and reporting, maintaining accurate records of the incidents, investigations, and actions taken.
- Support for staff and patients. Providing emotional and psychological support to everyone affected, including the health workers, patients, and attendants.

Note: To foster effective incident management, not only organizational efforts but also a clear legal framework that protects the rights of reporters is essential In Japan, such a framework has been established to support a culture of open and fair reporting. It defines legal protections, limits punitive measures, and emphasizes learning and transparency.

The four key elements are outlined below:

1. ***Legal Protection for Reporters:***

   Japanese law mandates that staff who report incidents or near misses are protected from punishment or blame. This legal guarantee is fundamental to building trust in the reporting system.

2. ***No Criminal or Disciplinary Penalties (Except in Cases of Crime or Gross Negligence):***

   Only in cases involving criminal acts or severe professional misconduct are serious penalties (such as criminal charges) considered. Routine mistakes and near misses are not subject to punitive action. Health service providers are expected to perform their duties to the best of their knowledge and practice to avoid infringing against the law.

3. ***Recognition and Positive Feedback:***

   The system should explicitly value staff who report frequently, treating robust reporting as a mark of professionalism and engagement, and recognising or appraising those who contribute positively to safety culture.

4. ***Learning Over Blame:***

   The ultimate focus is on organizational learning, transparency, and continuous quality improvement—not on assigning blame to individual staff members.

4 Incident Management Process

This handbook describes how to respond mainly to non-fatal incidents and near misses rather than adverse events involving death or severe sequelae. Serious adverse events should be handled in accordance with the reporting and response systems regulated at each health facility under the guidance of the Ministry of Health.

Incident management generally includes the following phases. At each health facility, the order may be slightly different, or different terms may be used. Importantly, the phases should support the implementation of the best practice principles of incident management.

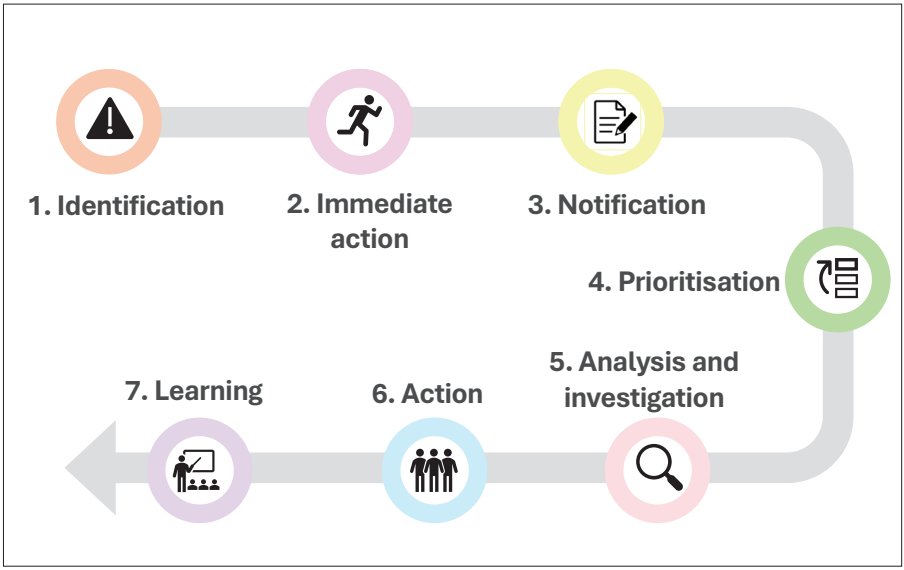


Figure 4: Incident Management Flow

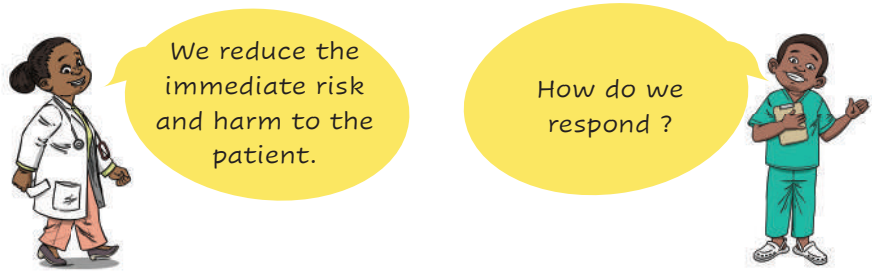
4-1. Identification

All events that threaten patient safety, regardless of whether they are medical incidents or not, should be identified. A patient fell from a bed without a handrail and was injured. The wrong dose of medication was administered to a patient. An oxygen cylinder collapsed, but no one was nearby. The left eye, not the diseased right eye, was almost operated on…Various events occurred in a health facility; the essential thing for the workforce is, however, to spot promptly when things have gone wrong. Health facilities should clearly define the purpose of their incident management system, outlining what must be reported and their expectations for the workforce. This should include incident definitions that are clear and easy to understand for everyone.

Incidents can be identified through various sources, for example, direct observation, team discussion, clinical review meetings, death review processes, staff meeting discussions, complaints from patients and visitors, inputs from patients, attendants, and family members, such as inquiries, concerns, and other information, monitoring variants in clinical practice, and medical records review.

Proactive strategies, such as observation of clinical settings, regular briefings and debriefings, and structured interviews involving healthcare staff and/or patients, family members, and other stakeholders can help spot errors or prevent them.

4-2. Immediate action to minimize risk and harm



When an incident is identified, it is crucial to take immediate action to mitigate the risk to the patient and anyone else who may be negatively affected.

The provision of immediate care to the individuals involved is essential. The target individuals include the patients, attendants, family members of the patient, and the healthcare staff in charge of the patient.

Ensuring safety at the actual scene is crucial, together with the immediate notification of the event to the responsible PSFPs and the QIT of the health facility.

Additionally, the staff involved must promptly seek assistance from the medical team or specialists for further evaluation or specialised care as needed. Furthermore, it is essential to temporarily remove or manage any equipment involved properly until a thorough investigation is completed.

Basic information on the precise sequence of events must be collected before the staff's memories become unclear or lost, for example, within 24 hours.

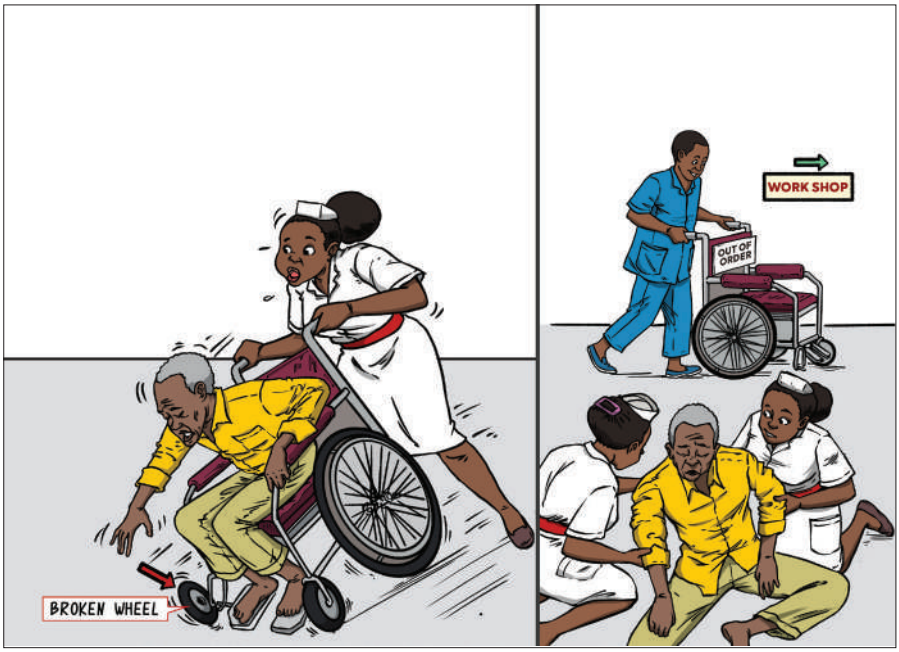


Figure 5: Provide immediate care to those involved and keep the scene safe by removing the source of the incident.

4-3. Notification

Documentation and reporting incidents should be straightforward, requiring minimal time and effort. To ensure openness, anonymity when reporting should be respected. Not only health workers, but also patients, attendants,

and visitors should also have a simple means of notification of the incidents to the staff. Creating an environment that allows easy and secure access to reporting tools is the initial step, such as making reporting forms available to pick up or providing access to an online form through a link or QR code.

Near misses should be recognized as valuable chances for improvement. Therefore, even if no patient was harmed in the end, proactive reporting is crucial, and reporting of near misses should be actively encouraged. When one reports an incident, it is essential to ensure the accuracy, quality, and completeness of the report to facilitate effective follow-up and review.
Key considerations for those who report incidents, including near misses, are summarized as (1) provision of the details of the event, particularly with objective and factual information. (2) the timeline of the incident should be well-documented, notifying the actual time of the occurrence. (3) avoidance of the identifiable names of the staff who were actually related to the event. (4) documentation of relevant facts and the incident ID number in the patient's medical record.

Health Facility Patient Safety Report (HPSR)

It is HPSR that helps you to report the event (incident or near miss) efficiently. By using a form that covers the minimum required fields, all the staff can report in the same manner without omissions. Detection of incidents must rely on reports from each staff member. Fostering a reporting culture by making it an organizational norm to report confidently whenever you encounter or experience an incident or near miss will lead to establishing a safety culture. The introduction of HPSR is an essential first step in this direction.

Incident reporting by HPSRs refers to collecting medical incident data to enhance patient safety and quality of care, not for any form of sanction or blame. When implemented effectively as a facility-wide system, this reporting system guides the development of interventions to mitigate risks, ultimately reducing harm through the 5S-KAIZEN and other means. The significance of HPSR and the details are discussed later in Chapter 5, Health Facility Patient Safety Report.

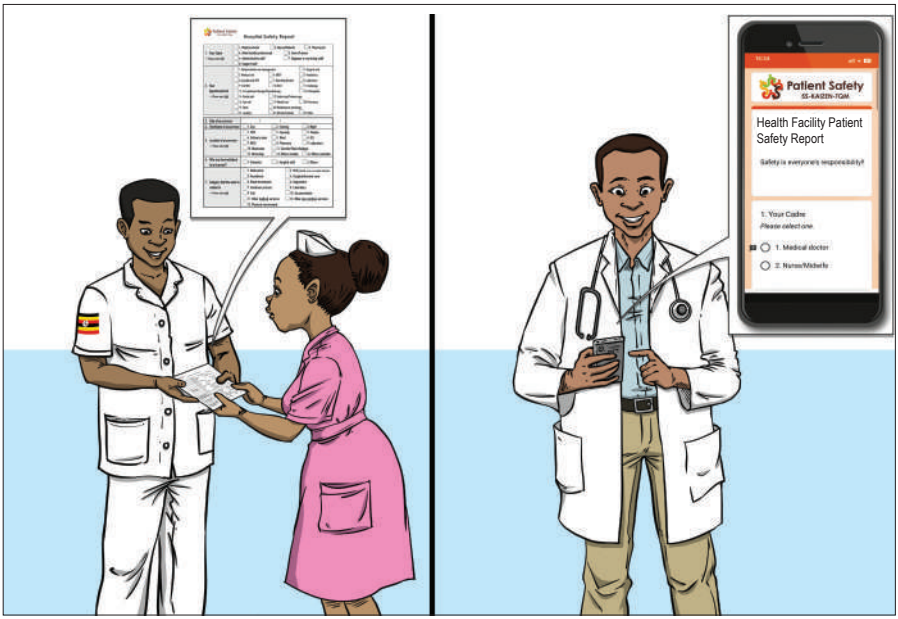


Figure 6: Notifying an incident/near miss through the HPSR system

Notification to patients

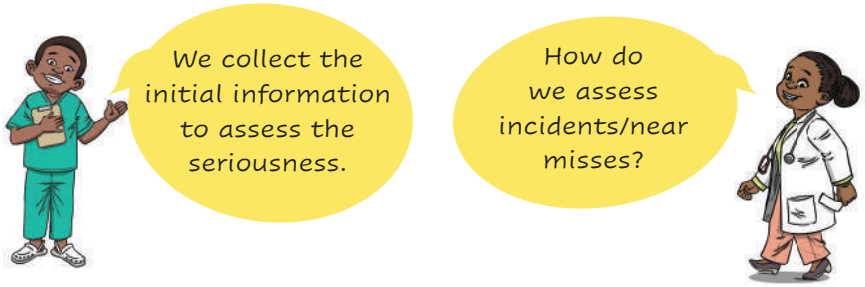
The incident should be acknowledged and explained to the patient, attendants, and family. Open disclosure helps effectively restore patient confidence in clinicians, health staff, and the health care system when it is done as soon as practicable. The statement should include a factual description of what happened, an apology or expression of regret, and the steps being taken to manage the event and prevent it from happening again. The person responsible for communicating the incident to the patient and their family should be determined according to the seriousness and potential impact of the event: Near-misses and incidents that caused no harm: These can be explained by the healthcare provider directly involved (such as the attending nurse or clinician), as they are best positioned to answer questions about what occurred in the moment.

Incidents resulting in actual harm or significant impact: These should be disclosed by the primary doctor (responsible physician) or, when appropriate, by a senior member of the health facility management (such

as the Senior Executive Consultant or designated leader), preferably in a private and supportive setting.

This approach fosters transparency and trust while also reflecting practices common in other countries, where clinicians provide explanations for events resulting in harm, and other staff may offer explanations for incidents without harm. While these principles provide guidance, each facility should exercise judgement and consider the context and needs of the patient and family.

4-4. Initial assessment and Prioritization



To effectively assess the incidents/near misses, the PSFPs under the guidance of QIT should undertake the following steps:

(1) Review the Incident Promptly: Examine the incident within the timeframe established by the organization (for example, weekly).

(2) Ensure Notification Accuracy: Verify the accuracy, quality, and completeness of the incident report, updating it with any additional relevant information.

(3) Assign a Risk or Severity Rating: Determine an appropriate risk or severity rating for the incident.

Note: Criteria for risk or severity rating differ across countries or local governments. Expertise from other countries, such as Australia, South Africa, and Japan, can be consulted for risk and severity assessments. The table below shows the severity level in Japan recommended by the National University Hospital Council of Japan.

Table 1. Incident severity classification in Japan

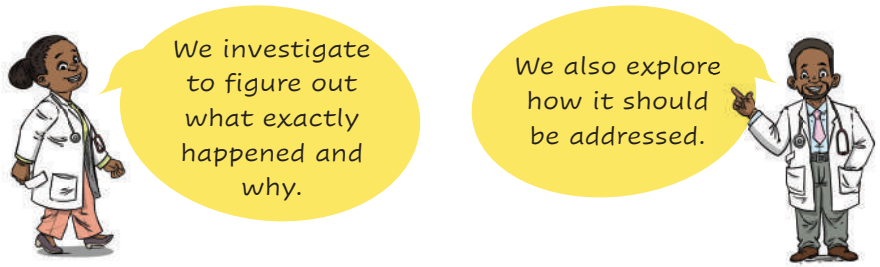
Level	***Continuity of injury***	***Severity of injury***	***Outcome/Treatment of injury***
Level 0	*-*	*-*	*Error or trouble with a pharmaceutical or medical device was found, but did not affect the patient (near-misses)*
Level 1	*None*	*-*	*There was no harm to the patient (but there was a possibility of some influence (An incident of no harm)*
Level 2	*Transient*	*Mild*	*Treatment was not necessary (mild change in vital signs, need for increased patient observation, examination for confirmation of safety, etc.)*
Level 3a	*Transient*	*Moderate*	*Simple treatment was required (disinfection, poultice, skin suture, administration of analgesics, etc.*
Level 3b	*Transient*	*Severe*	*Substantial treatment was required (significant change in vital signs, use of artificial respirator, surgery, prolongation of hospitalization, hospitalization, fracture, etc.)*
Level 4a	*Permanent*	*Mild to Moderate*	*Permanent disability or subsequent complication remained, but was not accompanied by significant dysfunction or an aesthetic problem*
Level 5	*Death*	*-*	*Death (excluding those due to the natural course of the underlying disease)*

(4) Agree on Open Disclosure Procedure to the Patient, Family, and their Attendants: Decide on the procedure of Open Disclosure based on the incident's severity.

(5) Notify Senior Leadership: Ensure that the Senior Executive Consultant, superintendent, or their equivalent is informed of all incidents that warrant the highest level of severity.

This assessment is pivotal for prioritizing further responses and determining the appropriate level of investigation and action required.

4-5. Analysis and Investigation



The primary objective of this investigation is to assess the system rather than to assign blame to the individuals involved. Ideally, the team most relevant to the site, the WIT, should spearhead these activities to understand what happened, how it occurred, and why, as well as to identify actions that can prevent similar incidents, and the type and level of investigation should be determined by the risk or severity decided in the previous step.

The investigation should adhere to the following principles:

(1) Fair Procedures: Conduct the investigation in accordance with principles of fairness and natural justice.

(2) Documentation: Ensure that all findings are documented in line with established policies and procedures.

(3) Objectivity: Maintain an impartial approach, free from value judgments.

(4) Multi-Disciplinary Involvement: Engage a multi-disciplinary team to conduct the investigation.

(5) Independent Oversight: Senior Management of health facilities to involve an independent or external investigator for complex incidents.

(6) Actionable Recommendations: Produce recommendations for approval and implementation by the organization.

Patients, their attendants, and families should be considered as essential partners in the investigation process. It is vital to facilitate and support patients, attendants, and families in sharing their experiences. Also, the investigators must communicate clearly with the stakeholders on the nature of the investigation, its timeframe, and how feedback will be provided regarding findings and recommendations.

In cases where questions of professional misconduct or unsatisfactory conduct arise, these should be managed according to the health facility's performance management processes based on the state legislation and registration requirements.

Each health facility should ensure appropriate levels of responsibility for investigating and addressing all incidents. Based on the above, workable procedures should be in place for incident investigations using validated methodologies. Access to training programs for conducting investigations should also be essential so that the staff can gain the necessary knowledge and conceptual skills, which can be useful in handling incidents. Sufficient resources should be, therewith, allocated to enable effective investigations on site. Quality Improvement Team (or equivalent) provides oversight of the quality and efficiency of investigation processes, outcomes, and actions taken to address identified issues and the countermeasures.

Classification is the systematic process of capturing relevant information from diverse viewpoints regarding an incident. This ensures a comprehensive understanding of its nature, including contributory factors. A robust classification system allows, over time, for data comparison within the organization.

4-6. Action

As repeatedly emphasized, the primary purpose of incident reporting is to prevent the recurrence of similar or worse events. Therefore, remedial actions must not be ad hoc but should serve as a robust defense against future recurrences.

Recommendations raised should address the root causes identified in the course of investigation or analysis.

- Incorporate suggestions for improvement from all staff, including frontline clinicians.
- Consider the patient's perspective and include suggestions for improvement from patients, their attendants, and families.
- Include a specific timeframe for implementing each recommendation.
- Recommendations and action plans should be approved by Quality Improvement Teams when required.

Remedial actions can be developed using a variety of methods. Examples include revitalizing 5S activities, refining operational procedures, and expanding the use of Standard Operating Procedures (SOPs), implementing small-scale KAIZEN improvements, or undertaking full-scale KAIZEN initiatives. For more information on 5S and KAIZEN, refer to Chapter 6, which addresses 5S-KAIZEN-TQM in incident management.

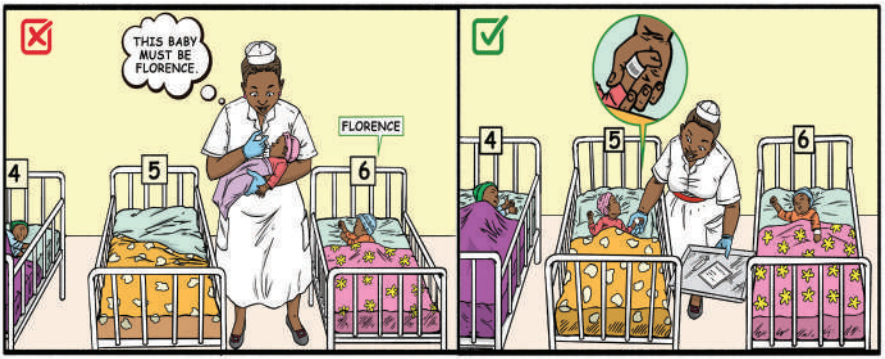


Figure 7. An example of actions taken after the near miss occurred.

PSFPs should conduct ongoing monitoring to support Work Improvement Teams (WITs) and ensure that recommendations are implemented within the agreed-upon timeframe. Simultaneously, PSFPs, with a mandate from the Quality Improvement Teams (QITs), should maintain a record of all recommendations and actions taken. PSFPs are also responsible for assessing whether the incident and related recommendations have relevance to other areas within the facility. When these steps are completed, the QIT and PSFPs can develop a practical plan to implement recommendations across the organization. The success of all actions taken should be systematically evaluated to prevent setbacks and identify opportunities for further improvement. Records of recommendations and action results should be regularly reviewed by QIT.

4-7. Learning

4-7-1 Feedback

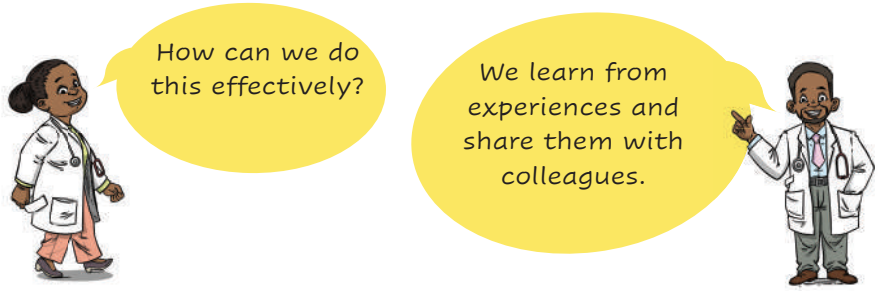
A key to a successful incident management system is providing timely and relevant feedback to stakeholders. Feedback should be provided by WITs with support from the PSFPs and the investigation team obtaining a consensus with the clinical team leader involved in the event. The targets of feedback are (1) the patient and his or her family members, (2) clinical team members engaged in the care of the patient, (3) QIT, and (4) Other health facility staff at various levels and categories.

The communication methods should be simple but rational through existing information-sharing practices. Only existing factual information must be shared in a manner appropriate for each audience. As a forum for sharing lessons learned, (1) general morning assemblies, (2) ward meetings, and (3) Continuous Medical Education (CME) sessions offer practical opportunities to disseminate information to a broader workforce. Timely and meaningful feedback to all stakeholders is essential. Communicating safety improvements resulting from incident reports encourages staff to report future safety concerns, fostering a culture of continuous improvement.

The PSFPs/ WITs, in collaboration with the investigation team involved in the event, should regularly report to the QIT on the details of the incident and its outcomes. At the same time, trending and aggregated data on safety incidents should be summarized quarterly and provided to the QIT to give them an understanding of the current state of their safety standards.

By conducting the mentioned activities, health facilities in Uganda will be able to enhance their incident reporting systems and promote a culture of openness and safety improvement. This approach helps build trust among staff, patients, and families, leading to better healthcare outcomes.

4-7-2 System-wide learning and sharing



System-wide learning involves several key activities: implementing recommendations broadly in similar and applicable contexts, monitoring the effectiveness of these implementations, and providing feedback to the workforce, executive leadership, the board, and the wider community. This feedback loop ensures continuous improvement and reinforces a safety culture.

In addition to individual incident analysis, aggregated, themed analysis of all safety data (not just incident reports) is crucial. This informs strategic improvement plans and projects. These analyses can be conducted at the unit level by Work Improvement Teams (WITs) or at the organizational level by PSFPs/QIT.

Facility-wide analytical work performed as a team is a critical task for PSFPs, who are certified patient safety professionals. This is in addition to the individual feedback processes. Quantitative analysis allows for the aggregation of incident data across the organization. This data can be categorized by type (near miss/incident), job role, time of occurrence, and other relevant factors. Representing this data in tables or graphs helps identify incident trends and patterns, enabling the development of targeted countermeasures. By categorizing incidents into recurring patterns, the PSFPs can more effectively address common underlying issues.

Disseminating findings through a newsletter is an effective method for providing feedback to the entire organization after facility-wide analysis. The newsletter can present an objective view of reporting trends across different departments, which can motivate positive change. For example,

departments with a large number of HPSRs can be recognized, and their strategies can be replicated. Departments with low reporting rates can be encouraged to increase their submissions.

Furthermore, accumulating and disseminating information about incidents on a broad, cross-departmental basis raises patient safety awareness among all staff. This demonstrates a facility-wide commitment to patient safety and helps build a stronger safety culture. Sharing lessons learned can also prevent similar incidents from occurring in different departments or units.

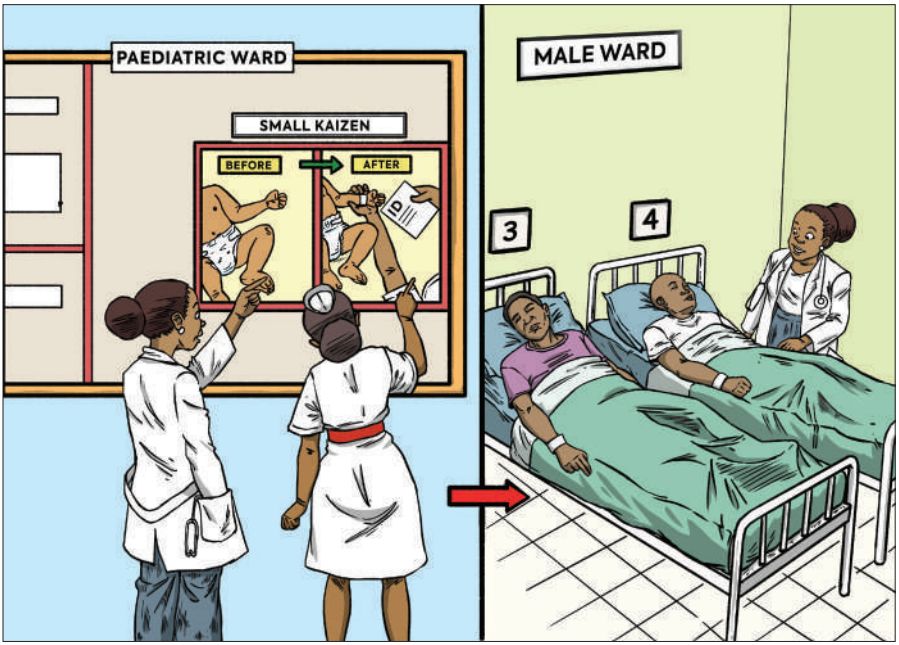


Figure 8. Sharing and introducing best practices throughout the facility

The key issues of feedback and learning.

Formal Feedback Mechanisms:

A structured feedback system should be established by QIT to acknowledge the reports, provide updates on investigations, and share the actions taken and improvements. It is well-documented that the success of incident management systems greatly depends on timely

feedback to staff on the results and outcomes of investigations.

Although not every report can be fully investigated due to volume, a clear policy should ensure that the staff/unit regularly receive acknowledgment and encouragement to keep reporting, even if their incident report has not been selected for analysis. WITs, with the support of PSFPs, assume the leading role in providing feedback on the ground.

WITs hold weekly meetings to discuss actions for addressing gaps arising from incidents/near misses and other QI concerns. As part of a formal feedback mechanism, the WIT submits the report regularly to the department, PSFPs, and QIT.
Meanwhile, PSFPs share the summaries of aggregated data and lessons learned in staff meetings and with QIT/management to promote transparency, learning, and continuous improvement.

Regular Safety Meetings/Forums:

The QI committee meetings that take place at different levels in the national health system should include patient safety issues on their agenda. Staff and the other patient safety actors from different departments can use the opportunity to discuss patient safety concerns, share lessons learned from incidents, and collaborate on solutions/actions to improve the situation.

Training and Education:

Provide ongoing training and education on patient safety topics, including how to identify and report incidents. Use incident data to inform training programs and address specific areas of concern.

MoH support supervision and mentorship field visits, including performance review meetings at all levels, shall be used to build capacity for implementing patient safety practices at the different levels of care and support services.

Anonymous Reporting:

Ensure that staff can report incidents anonymously without fear of reprisal. This can encourage more open reporting of safety concerns.

Recognition and reward:

Recognition and rewarding of health service providers, departments, or units that identify potential safety hazards or prevent incidents from occurring is important in institutionalizing the implementation of patient safety practices. It reinforces the culture of vigilance and proactive safety behavior.

Standardized Reporting MoH Templates:

Reporting must be done using standardized MoH reporting templates to ensure that all relevant information is collected consistently across all incidents. Use of QR code shall be promoted to ease access to the tool and to have real-time reporting taking place.

Feedback Loop:

Emphasized the importance of closing the feedback loop by providing updates to those who report incidents and sharing lessons learned across the organization monthly.

5 Health Facility Patient Safety Report

Health Facility Patient Safety Report (HPSR) can be applied in all types of health facilities. Reporting safety concerns is essential to improve the safety of care. According to WHO (2020), reporting systems fulfill the following functions:

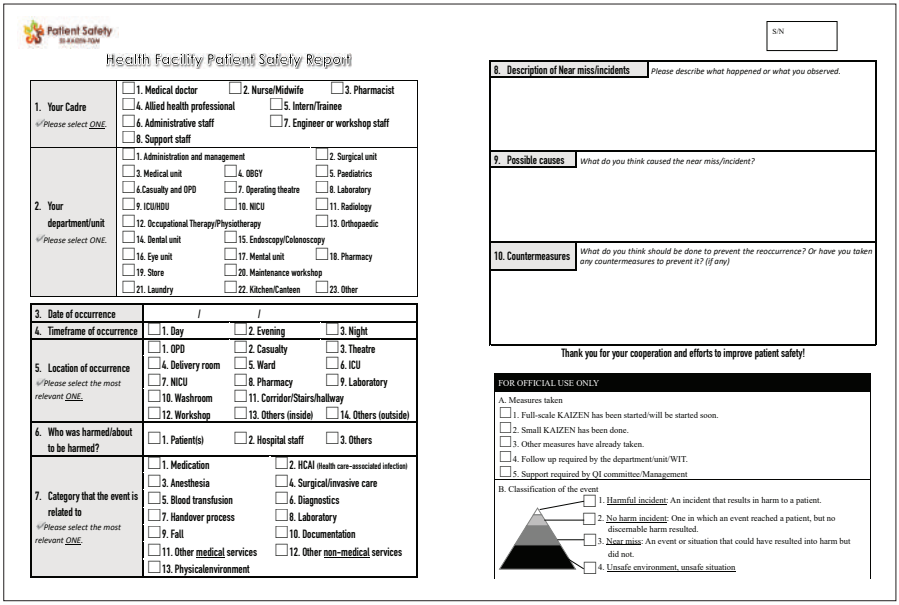
- Response to the patients and families involved
- Foundation for learning and improvement
- Public accountability
- Barometer of risk within healthcare
- Communications alert route

It should be noted, however, that the number of these safety reports does not always reflect the actual number of adverse events or incidents. Rather, the number of reports signifies organizational accountability, transparency, and efforts toward patient safety.

Minimal Information Model (MIM)

The MIM for patient safety, developed by WHO, is described as a structured template containing the definition and the rationale for every entity (category or relationship) of a minimal adverse event reporting system. In Uganda, the prototype of an incident reporting form was developed to fit the context of our country with reference to this model.

Definition and purpose of each item in HPSR



Patient Safety

Health Facility Patient Safety Report

S/N

1. Your Cadre ✓Please select ONE.	☐1. Medical doctor ☐2. Nurse/Midwife ☐3. Pharmacist ☐4. Allied health professional ☐5. Intern/Trainee ☐6. Administrative staff ☐7. Engineer or workshop staff ☐8. Support staff
2. Your department/unit ✓Please select ONE.	☐1. Administration and management ☐2. Surgical unit ☐3. Medical unit ☐4. OBGY ☐5. Paediatrics ☐6.Casualty and OPD ☐7. Operating theatre ☐8. Laboratory ☐9. ICU/HDU ☐10. NICU ☐11. Radiology ☐12. Occupational Therapy/Physiotherapy ☐13. Orthopaedic ☐14. Dental unit ☐15. Endoscopy/Colonoscopy ☐16. Eye unit ☐17. Mental unit ☐18. Pharmacy ☐19. Store ☐20. Maintenance workshop ☐21. Laundry ☐22. Kitchen/Canteen ☐23. Other
3. Date of occurrence	/ /
4. Timeframe of occurrence	☐1. Day ☐2. Evening ☐3. Night
5. Location of occurrence ✓Please select the most relevant ONE.	☐1. OPD ☐2. Casualty ☐3. Theatre ☐4. Delivery room ☐5. Ward ☐6. ICU ☐7. NICU ☐8. Pharmacy ☐9. Laboratory ☐10. Washroom ☐11. Corridor/Stairs/hallway ☐12. Workshop ☐13. Others (inside) ☐14. Others (outside)
6. Who was harmed/about to be harmed?	☐1. Patient(s) ☐2. Hospital staff ☐3. Others
7. Category that the event is related to ✓Please select the most relevant ONE.	☐1. Medication ☐2. HCAI (Health care–associated infection) ☐3. Anesthesia ☐4. Surgical/invasive care ☐5. Blood transfusion ☐6. Diagnostics ☐7. Handover process ☐8. Laboratory ☐9. Fall ☐10. Documentation ☐11. Other medical services ☐12. Other non-medical services ☐13. Physicalenvironment

8. Description of Near miss/incidents	*Please describe what happened or what you observed.*
9. Possible causes	*What do you think caused the near miss/incident?*
10. Countermeasures	*What do you think should be done to prevent the reoccurrence? Or have you taken any countermeasures to prevent it? (if any)*

Thank you for your cooperation and efforts to improve patient safety!

FOR OFFICIAL USE ONLY

A. Measures taken

☐1. Full-scale KAIZEN has been started/will be started soon.
☐2. Small KAIZEN has been done.
☐3. Other measures have already taken.
☐4. Follow up required by the department/unit/WIT.
☐5. Support required by QI committee/Management

B. Classification of the event

☐1. Harmful incident: An incident that results in harm to a patient.
☐2. No harm incident: One in which an event reached a patient, but no discernable harm resulted.
☐3. Near miss: An event or situation that could have resulted into harm but did not.
☐4. Unsafe environment, unsafe situation

Figure 9. Template of Health Facility Patient Safety Report (HPSR) form

(1) Reporter's information (Item #1 and #2)

- Your cadre
- Your workplace

Though HPSR is anonymous, reviewing and comparing report submissions by cadre and department/unit encourage proactive reporting across the facility.

According to a study conducted in Japan, reporting incidents by medical doctors reflects organizational transparency the most and is the drive toward patient safety and quality improvement in healthcare (Fukami, Uemura, and Nagao, 2020). For a successful reporting system and active patient safety programs, PSFPs must encourage medical doctors' involvement in reporting and devise ways to increase the number of reports from them.

(2) Incident identification (Item #3 to #6)

- Date **WHEN**

- Timeframe **WHEN**
- Location of occurrence **WHERE**
- A person who was (about to be) harmed **WHO**

These items not only provide basic information about the incidents/near misses but also help PSFPs and WITs plan proactive measures by identifying the timeframes and places where unfavorable events are most likely to occur.

(3) Category of the event (Item #7) WHAT

Categorizing events by types or areas of errors (e.g., medication error, HCAI, handover process) will help PSFPs identify trends in incidents/near misses across the health facility and take collective remedial action.

(4) Description of Near miss/incidents (Item #8) WHAT

In this section, you should describe what happened or what you observed in sentences, concisely and precisely. The report should be complete, concise, and specific as explained under the section titled "What is a good report?" on the next page of this document.

(5) Possible causes (Item #9) WHY

You write here your thoughts on why it happened, for example, what you observed or experienced that may have caused the incident/near misses.
It should be noted, however, that the actual causes of the incident can only be identified after a root cause analysis has been performed, and PSFPs and WITs should not rely on the causes described here.

(6) Countermeasures (Item #10) HOW

Your ideas or suggestions on how to prevent recurrence are described.

(7) Official use

- Measures taken (Item A)
- Classification of the event (Item B)

Item A is used as an index for PSFPs to follow up after an incident/near miss. Item B is to categorize the events according to their severity, and, like item 5 above, it can be used to identify the trends within the health facility. PSFPs should make an effort not only to increase the overall number of reports

but also to increase the number of near misses reported. This is because prevention and awareness of minor events, namely near misses, are crucial to preventing a single serious accident.

What is a "good report"?

1. Completeness

A good report covers the essential elements of who, what, where, when, how, and why (5W1H). The emphasis on each of these elements may vary depending on the type and complexity of the incident.

2. Conciseness

While a report should be comprehensive, it must also be concise. This means including only important details and avoiding unnecessary words that may impede readability.

--Examples--

✘Too many words and or phrases
The running water of the hand-washing basin in the operating theatre was examined with a microbiological method and found to be contaminated with Escherichia coli.

✓Concise, having minimal requirements for information
The water of the surgical handwashing area was found to be contaminated with E. Coli.

3. Specificity

Reports should be specific to provide clear information. Dates, times, and contents should be detailed and precise.

--Examples--

✘Unclear: The patient visited the Emergency in the early morning yesterday.

✓Specific: The patient was met by the Emergency receptionist at 5:30 p.m. yesterday.

4. Objectivity and Factual Accuracy

A well-written report is factual and fair. It should focus on verifiable facts rather than opinions or speculations. Facts are real and can be either proven or disproven. Avoid using subjective language or making assumptions.

--Examples--

✘Speculation: The pregnant mother was weak under the influence of bad nutrition, as the nurse who met her at OPD felt that she was from a poor family.

✘Personal opinion: The patient was suffering from malnutrition.

✓Factual: Iron deficiency anaemia was suspected by blood tests with the haemoglobin 9.0g/dL and Serum Ferritin 9.5ng/mL.

5. Use of Abbreviations

While standard abbreviations are acceptable in incident reports, excessive or inappropriate use can confuse readers. Limit abbreviations to those that are widely recognized and necessary for clarity.

Barriers to HPSR

Under-reporting of adverse events and medical errors is common. Public health researchers estimate that only 10-20% of errors are ever reported and of those, 90-95% cause no harm to patients. Therefore, the adverse events that harm patients are not being reported and examined. Under-reporting may be due to several common barriers to incident reporting.
Assess the potential barriers to reporting in your organization on a regular basis, beginning with the examples below:

- Worry over legal ramifications
- Blame and shame culture, guilt, fear of punishment
- A lack of time to report
- No easy reporting system
- No trust in follow-up/repeated reports with no follow-up
- Already reported the same event in the past
- Details are lost with time

- Lack of encouragement from top management and/or colleagues
- No analytic feedback on the periodic safety report

According to a study conducted in Australia, lack of or inadequate feedback was identified as the major barrier to both doctors and nurses, followed by other organizational factors relating to structures and processes for reporting, such as long forms and insufficient time to report (Evans, Berry, Smith, et al, 2006). Therefore, PSFPs should always strive to provide timely and meaningful feedback to the relevant people when an event occurs.

6 5S-KAIZEN-TQM in Incident Management

Effective management by a well-motivated workforce promotes better research outcomes positively affecting the protection of people's lives. Cynicism on routine managerial practices, if any, should be eliminated through mindset change and positive attitude strengthening.

5S-KAIZEN-TQM is a three-step approach that can be applicable to any organization. The three elements of this approach are all essential to uplift productivity and quality of the organizational outputs. As you are well informed, 5S Principles (Sort, Set, Shine, Standardize, Sustain) are the tool for Work Environment Improvement (WEI), which is the precondition for the implementation of KAIZEN and TQM.

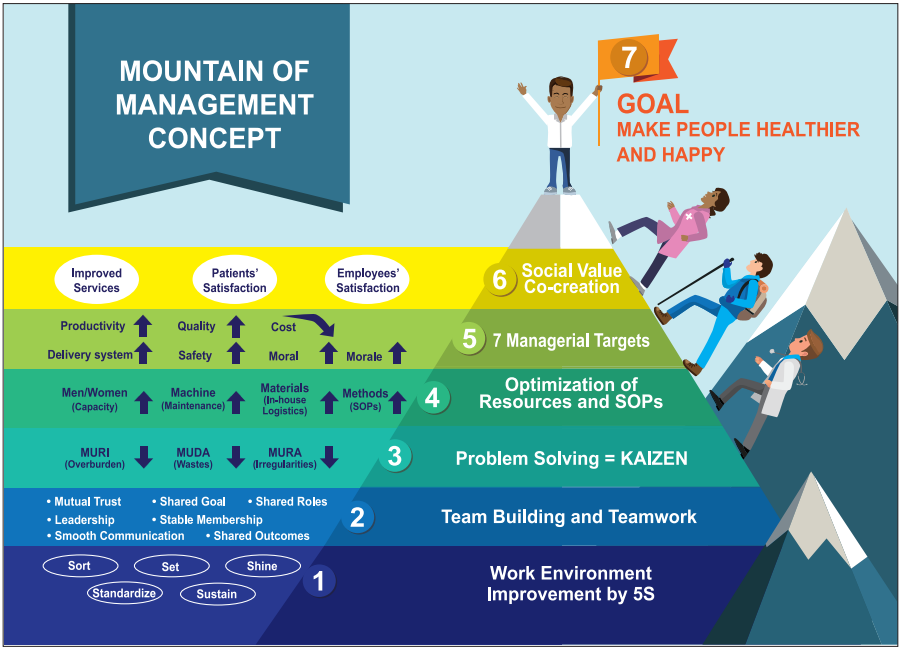


Figure 10: Conceptual Framework of Hospital Management – Mountain of Management

6-1. Linkage with 5S activities

5S Principles *(Sort, Set, Shine, Standardize, Sustain)* are the tools for Work Environment Improvement (WEI), which is the prerequisite for the implementation of KAIZEN and, in turn, the realization of Total Quality Management (TQM).

By incorporating 5S activities into routine healthcare procedures, 5S not only enhances the work environment but also contributes to the resolution of numerous safety concerns that have been identified in the HPSRs, such as:

- Risk of picking and/or using the wrong items
- Misidentification of patient for surgery
- Mislabeling of specimens for laboratory investigation
- Use of faulty equipment
- Risk of contamination and infections due to poor waste segregation
- Long response times in critical situations due to failure in triage.
- Inappropriately labeled shelves, drawers, and cabinets contribute to a poor workflow

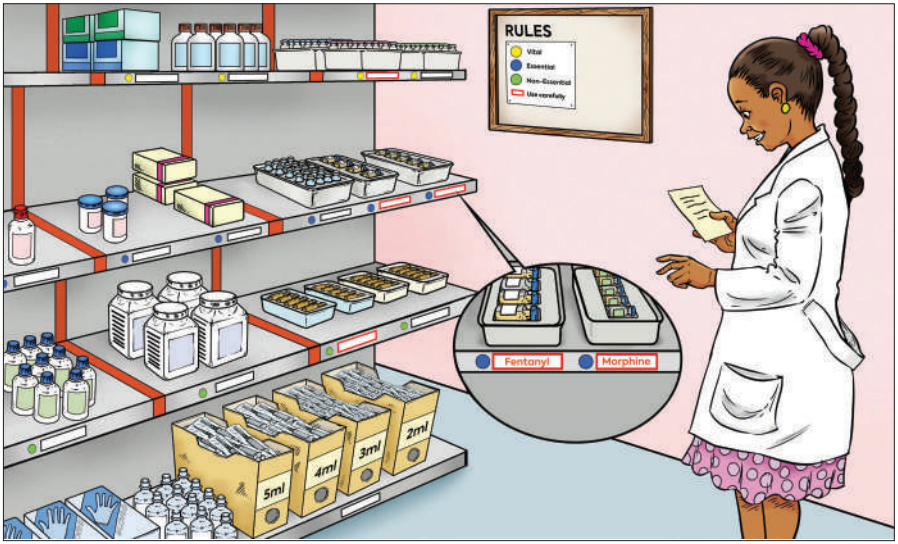


Figure 11. An example of 5S activities color coding and well-designed labelings that contribute to patient safety (1) Pharmacy

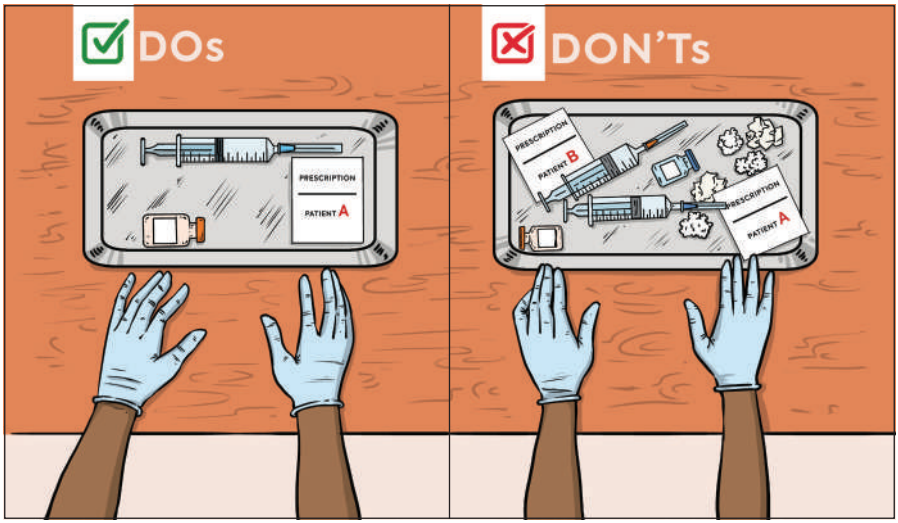


Figure 12. An example of 5S activities – Sorting and Setting – that contribute to patient safety (2) Trays with syringes, ampules, and prescriptions

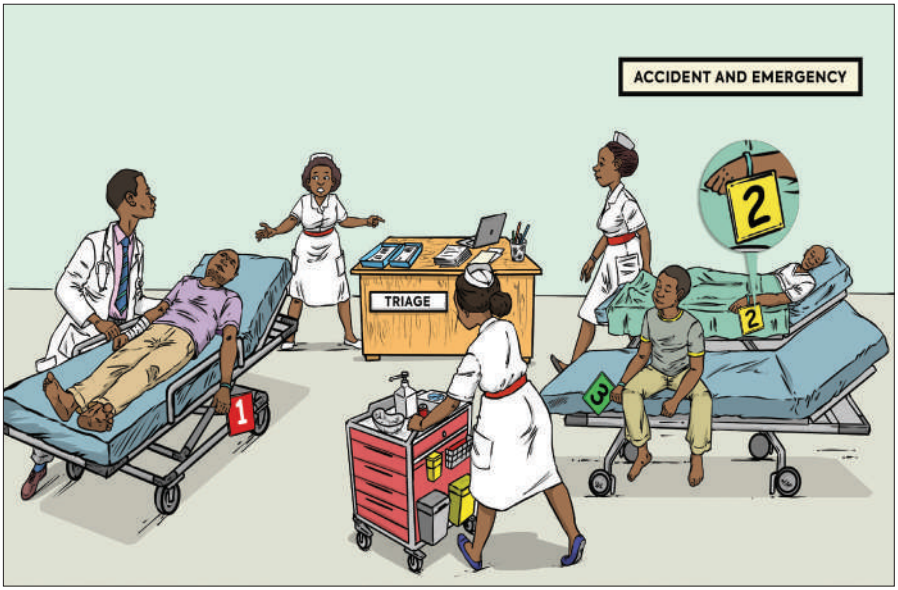


Figure 13. An example of 5S activities Color codes –that contribute to patient safety (3) Triage at the Emergency

6-2. Linkage with KAIZEN

KAIZEN is a term in the Japanese language meaning "continuous improvement". Mainly in the manufacturing sector, the English term "Continuous Quality Improvement (CQI)" has been used as the translation of KAIZEN. The target of KAIZEN is, however, not only quality. Every key managerial issue, including safety, cost, service delivery system, morals, morale, and productivity, comes to be the target upon necessity with KAIZEN's direct effects on personnel, hardware, in-house logistics, and work methods.

KAIZEN, a widely recognized problem-solving framework, comprises seven distinct steps as illustrated in Figure 14.

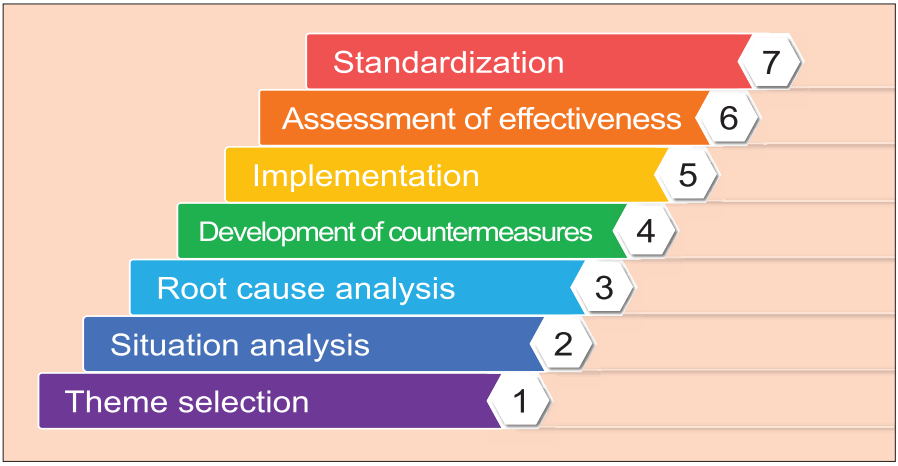


Figure 14. 7 steps of KAIZEN – QC story

1. KAIZEN theme selection from the various problems existing in your work territory.
2. Situation Analysis on the selected KAIZEN theme to clarify the nature of the problem and its implication on your work processes.
3. Root Cause Analysis (RCA) is a process to identify the root cause(s) of the problem identified in the situation analysis. The root cause(s) come to be the target(s) of problem-solving.

4. Development of countermeasure(s) with specific objectives of problem-solving.
5. Implementation of the countermeasure(s) which are the actual processes for eliminating the root causes.
6. Assessment of Countermeasure(s)' effectiveness as the monitoring and evaluation.
7. Standardization or institutionalization making use of the problem-solving results to prevent the setback after the completion of problem-solving.

If 5S activities are in practice at all areas of the facility, the majority of problems of the physical environment could be solved in the given 1-2 years. The continuation of 5S is, thereafter, needed further to maintain the improved situation and, in case, to react to the ad hoc change of physical surroundings. Based on this enabling work environment guaranteed by ongoing 5S activities, KAIZEN attempt could be vitalized by the small efforts of the staff's teamwork.

Similar to the 5S activities, KAIZEN should not be a job that solely relies on personal interests and efforts. It should be conducted as a team effort as part of the routine work of the respective work unit of the institute. If there are 20 departments or work units, every year, at least 2 work unit-based KAIZEN projects should be undertaken, ideally, in order for the entire facility to enhance both managerial and technical standards. The six-month timeframe is an appropriate duration for problem-solving. Naturally, some themes are simple enough to be resolved within a month or two, while others may require up to six full months, depending on the nature of the problems.

The problems with complexity cannot be resolved solely through the efforts of a single work unit. These problems should be temporarily put aside and excluded from the targets of problem-solving by KAIZEN. Consequently, you will have an opportunity to tackle them as Total Quality Management (TQM) activities that involve multiple work units and the management core group of the facility. KAIZEN is a problem-solving approach designed for topical or local optimization issues, while TQM is a large-scale, multi-disciplinary problem-solving approach suitable for addressing complex problems.

HPSR serves as a valuable resource for identifying potential issues in selecting themes for Step 1 of KAIZEN activities. Alternatively, KAIZEN methods can be effectively used for incident analysis and planning of collective remedial actions to prevent the recurrence of incidents reported in the HPSR. In addition, small KAIZEN should be extensively used as an immediate remedy for incidents and near misses with less complex causes.

For a deeper understanding of how KAIZEN is applied in incident management, refer to Appendix 4 for a case study of KAIZEN addressing catheter failures in a pediatric ward.

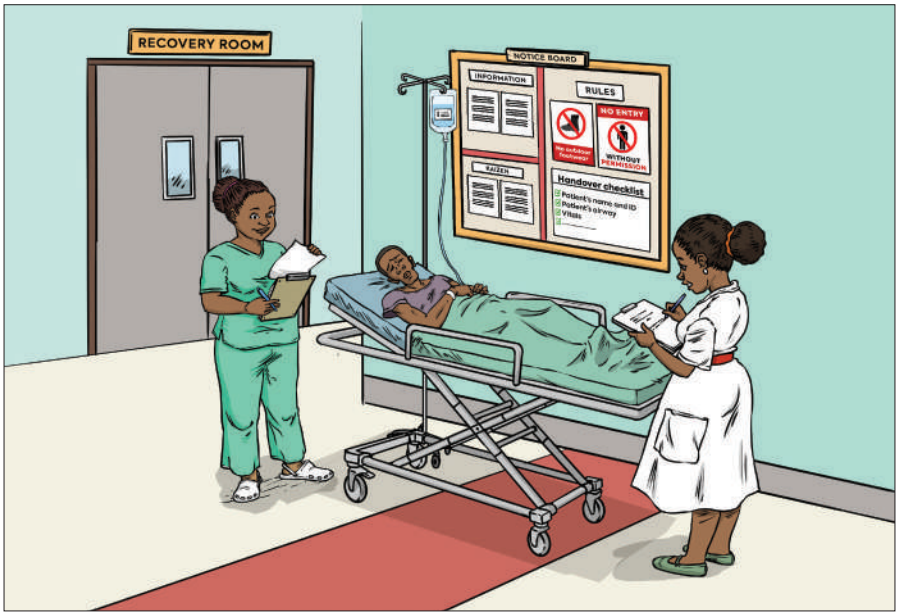


Figure 15. An example of KAIZEN implementation for the patient handover issues: Improving the communication between the operating room and the ward

6-3. Linkage with TQM

Total Quality Management (TQM) in the context of health facility management is a managerial framework grounded in the belief that an organization can achieve long-term success by engaging all its members—from entry-level staff to top executives—in a collective effort to enhance the quality of care. This focus on quality ultimately leads to increased patient and client satisfaction. To realize the effective implementation of TQM, top management and QIT need to provide relevant leadership that guides the entire workforce toward full participation in the TQM process.

To implement Total Quality Management (TQM) and generate concrete results in each healthcare service, there is a prerequisite: achieving the establishment of a "safety culture" as the core principle of the health facility's management and operational policies.

Without the provision of safe medical services as a prerequisite, improvements in the quality of medical care become meaningless. Establishing a safety culture in a health facility involves a step-by-step process of progressing through the five stages depicted in Figure 16. This process begins with optimizing internal safety standards, rules, and restrictions. If any necessary standards are absent, they must be promptly established. Additionally, existing standards must be continually enhanced to accommodate the introduction of new medical technologies and changing environmental factors.
Building upon this foundation, it's crucial to establish a facility-wide reporting system that collects information on near-misses and incidents during daily medical care provision to prevent future problems by taking proactive measures. This enables us to analyze the gathered information, implement appropriate countermeasures, and improve the work environment and processes to an obtainable best state.

Quality indicators related to each medical and non-medical service should be effectively utilized in this process. Only when there is a clear goal, which is reflected in standard procedures, can frontline staff comprehend the desired goals and take appropriate actions.

Under such circumstances, TQM is implemented under the leadership of the Senior Executive Consultant and other top management, with participants from all departments and levels of the organization, to address priority issues throughout the health facility. Through these efforts, the entire organization will gradually change and further improve safety and quality. This state of affairs and the organizational structure, including the actions and decision-making of those involved, is referred to as a "safety culture."

Now, a health facility organization that has achieved a safety culture sharpens the sensitivity of personnel at each level to identify problems and countermeasures for improvement. The health facility organization then continues to implement TQM, selecting themes as needed. Once one TQM is completed, the next is addressed, and even for TQMs that have been completed, new TQMs are implemented to maintain their effects over the long term.

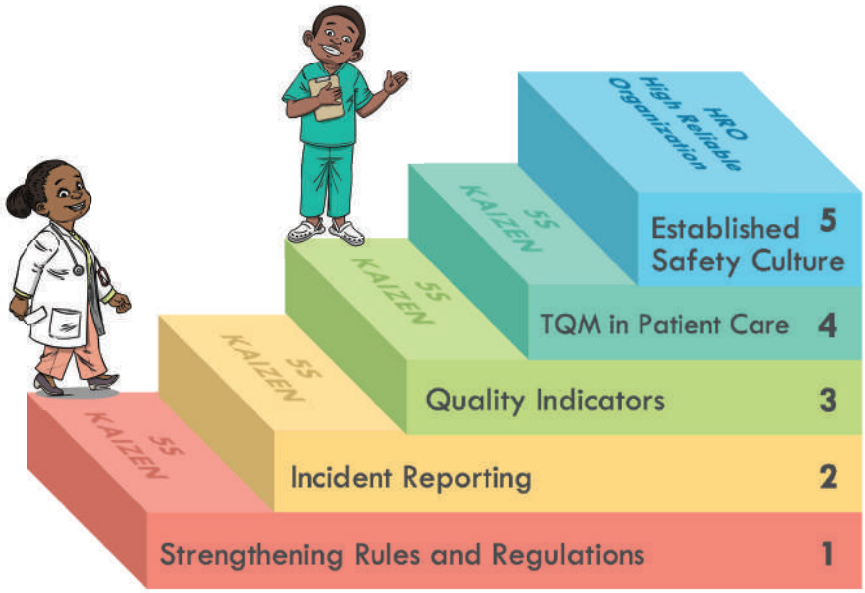


Figure 16. The safety culture and maturity model[1]

1 Hudson and van der Graaf, 2002, modified by Prof. A. Yasuda, Nagoya, Japan, and introduced to Uganda by the Project on Patient Safety Establishment through 5S-CQI(KAIZEN)-TQM in Nov. 2021

7 Roles and Responsibilities in Incident Management

7-1. National Level: Ministry of Health

While individual HPSR data should be managed by each health facility for confidentiality purposes, the Ministry of Health (MoH) plays an important role at the national level to ensure health facilities appropriately manage incidents to realize patient safety culture at the facility level.

Specifically, the MoH through SCAPP will:

(1) Develop and implement administrative policies and legal protection mechanisms.

(2) Review and monitor guidelines and policies to enhance patient safety.

(3) Encourage public and private health facilities to foster a strong reporting culture that facilitates proactive identification and remedial actions of incidents under the leadership of the health facility in-charges.

(4) Assist in securing the necessary budgetary, human resources, and other resources for each health facility to effectively manage incidents and further promote patient safety activities.

(5) Conduct regular support supervision and mentorship activities.

(6) Receive a quarterly summary of HPSR from RRH Public Health Departments (PHDs) (SCAPP-M&E Officers to manage and report).

(7) Incorporate patient safety issues, including the statistics of HPSR, in the MoH quarterly/annual performance review meetings and reports for QI.

(8) Collect and disseminate best practices from health facilities throughout the nation regarding patient safety promotion initiatives and the utilization of HPSR.

(9) Support implementation of community patient safety practices in the country.

7-2. Regional Level: Regional Referral Hospitals (PHDs)

RRH PHDs will:

(1) Support and coordinate regional implementation of the patient safety practices.

(2) Conduct regional support supervision and mentorship activities.

(3) Incorporate patient safety issues, including the statistics of HPSR, in the regional quarterly performance review meetings and reports for QI, and submit to the MoH.

(4) Support implementation of community patient safety practices in the region.

7-3. District Level: District Health Team

District Health Team (DHT) will:

(1) Support and coordinate district implementation of the patient safety practices.

(2) Conduct district support supervision and mentorship activities.

(3) Incorporate patient safety issues, including the statistics of HPSR, in the district quarterly performance review meetings and reports for QI, and submit to the RRH PHDs.

(4) Support implementation of community patient safety practices in the district.

7-4. Facility Level:

Figure 17 shown in the next page is an example of the structure of the Incident Management and HPSR system within a health facility. All facilities are required to establish a structure based on this model, while adapting it to their level of autonomy and specific context. To ensure operational flexibility, it is recommended that a patient safety team comprising trained PSFPs should be set up and function as a sub-committee under QIT.

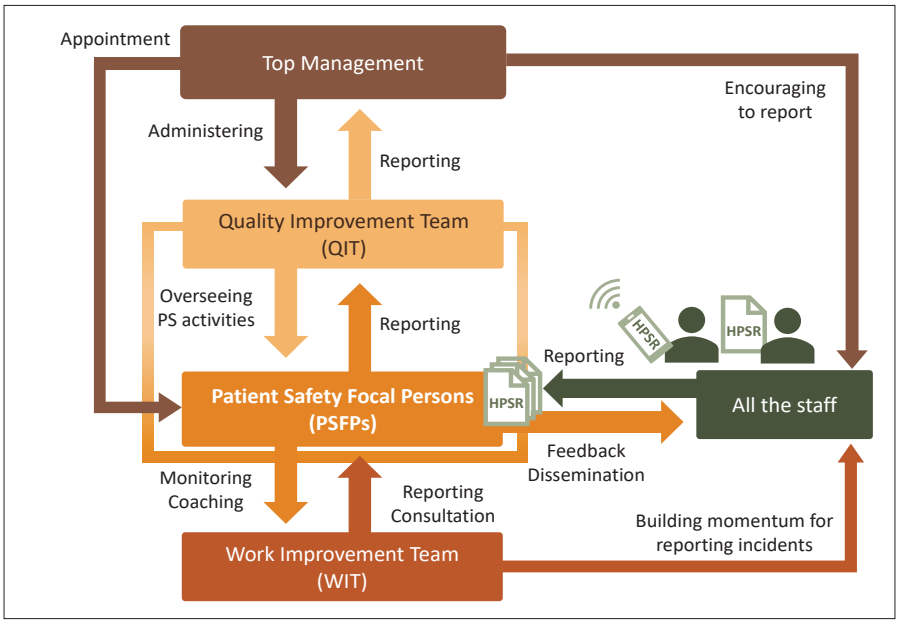


Figure 17: An example of the structure of the Incident Management/HPSR system

7-4-1. Health facility In-charges:

The health facilities in-charges will:

(1) Formally appoint Patient Safety Focal Persons (PSFPs) under the QIT.

(2) Ensure that all staff are encouraged to report through meetings, assemblies, and other fora and make visible the "No Blame No Punishment" policy except in exceptional circumstances of misconduct.

(3) Ensure that appropriate systems are implemented and necessary resources are allocated to report, investigate, and monitor actions aimed at preventing the recurrence of incidents.

(4) Ensure that adequate mechanisms are in place to facilitate the effective reporting, documentation, investigation, and implementation of recommendations following an incident.

(5) Ensure that there is adequate technical and information technology infrastructure to maintain high standards in all aspects of the incident reporting system.

(6) Provide for recognition and reward systems for departments and units that excel in reporting near misses and incidents.

(7) Evaluate and ensure rapid implementation of recommendations derived from incident analysis.

(8) Ensure that there is a framework in place to communicate and prioritise the risks identified by the reporting data and their analysis.

(9) Ensure the principles of open disclosure are observed when interacting with patients and their families or attendants at the time of the incident.

(10) Regularly carry out a survey of the organisation's safety culture to ensure relevance.

7-4-2. The Heads of Departments

The Heads of Departments will:

(1) Ensure that patient safety activities are incorporated into and implemented with planned QI activities.

(2) Oversee timely notification, sufficient investigation of incidents, actions taken, and record keeping of all these processes.

7-4-3. Quality Improvement Teams (QITs)

QITs will:

(1) Review the periodic reports of HPSR originating from the PSFPs, report to the top management, and supervise the activities of the PSFPs.

(2) Oversee the effective management of the incident reporting system.

(3) Assess and approve the recommendations developed by the WITs.

(4) Monitor the implementation of recommendations from incident reviews up to closure.

(5) Develop and incorporate patient safety activities into a comprehensive facility QI work plan.

(6) Act as a bridge between the top management and PSFPs, ensuring that the PSFPs effectively lead and facilitate activities related to patient safety.

7-4-4. Patient Safety Focal Person (PSFPs)

PSFPs will:

(1) Develop appropriate plans for training and education of facility staff on incident management principles and processes including the utilization of HPSR.

(2) Coordinate trainings on HPSRs for all health facility staff.

(3) Ensure the effective management of incidents reported and referred by staff.

(4) Ensure feedback on recommendations of incident reviews is provided to the patient and his/her family, the clinical team engaged in the care of the patient, QIT, and other relevant staff at various levels and categories.

(5) Provide support and advice to WITs in addressing and managing incidents through regular monitoring and mentorship.

(6) Assess the recommendations implemented by WITs and disseminate them to other departments/units if they are relevant.

(7) Aggregate HPSR data, analyze incident trends in the facility, and share the summarized report to QIT and/or the top management quarterly.

(8) Disseminate the findings of the analysis to the entire health facility on a regular basis.

7-4-5. Work Improvement Teams

WITs at the departmental/unit level will:

(1) Take the lead in the investigation and review of incidents at weekly WIT meetings.

(2) Derive recommendations from the investigation and analysis.

(3) Ensure that these recommendations are put into action in conjunction with the rest of the staff in the department/unit.

(4) Provide the feedback to relevant parties in a timely manner with the support of PSFPs.

(5) Keep a record of investigation, analysis, and recommendations implemented.

(6) Build momentum for submitting HSPRs when they identify the incidents/near misses.

7-4-6. All staff

All staff are responsible for:

(1) Making the scene safe to minimize immediate harm once an incident is identified.

(2) Notifying their designated PSFPs of an incident at the time of the event.

(3) Reporting all incidents and near misses.

(4) Participating in the investigation and review of incidents as required.

(5) Collaborating with the WIT and actively participating in the implementation of recommendations derived from the investigation of the incident.

(6) Encouraging each other to notify all incidents and near misses identified to realize the reporting culture.

(7) Attending all WITs and other QI meetings regularly.

8 Best practice case study – Forgotten tourniquet

This case study has been developed to illustrate the best practice principles outlined in this handbook.

1 Identification

Priscilla, a nurse working in a pediatric ward, was spoken to by a mother who was taking care of a patient, Brian, a 3-year-old boy. The mother said that Brian looked unwell and would not stop crying. Priscilla promptly rushed to his bedside and discovered a tight glove, used as a tourniquet, had been left on his arm.

2 Immediate Action

Priscilla removed the glove hastily and examined Brian's arm.

She noticed indentations and redness at the tourniquet site, and swelling, which led her to suspect that he was crying due to irritation or discomfort. Immediately, Sr. Mirembe, a senior nursing officer in charge, was informed, and a pediatrician on duty was called for further assessment.

Priscilla had not provided any treatment to Brian yet today due to other patients' care. Therefore, she checked the inpatient records to find

out what procedures he had received and how long the tourniquet had been left on. According to the record, Brian got a blood test done following the instructions from a doctor at the morning round. That is, the glove was forgotten on his arm for almost 2 hours.

His blood pressure and temperature were normal. The physical examination and neurological testing by the pediatrician revealed no muscular or circulatory injuries except for the weakness of the reflex on the affected arm. The pediatrician instructed the mother to take Brian for Physiotherapy, and Priscilla accompanied them.

Priscilla explained the situation to the physiotherapist, and Brian was promptly given a massage with topical anesthesia.

3 Notification

When Priscilla returned to the pediatric ward, she found that her colleague Afiya, a newly allocated nurse, was informing Sr. Mirembe that she had inadvertently forgotten to remove Brian's tourniquet in the morning due to her preoccupation with attending to other urgent patient emergencies.

Sr. Mirembe instructed Afiya to report this incident in the Health Facility Safety Report so that they could discuss with WIT and PSFPs on how to prevent a recurrence. Later, she then approached the mother and explained on behalf of the ward that the tourniquet had been left in place for two hours, leading to congestion and other minor symptoms, however, Brian's arm function had been restored through physiotherapy. Initially upset when the incident was discovered, the mother has since regained her composure and was attentively listening to Sr. Mirembe.

Priscilla encouraged Afiya, who was still new to her job in pediatrics, and assisted her in completing the HPSR. They also updated Brian's medical record with a summary of the incident.

4 Initial Assessment and Prioritization

In the afternoon of that day, Dr. Simon, one of the PSFPs, noticed a new HPSR submitted from the pediatric ward regarding a forgotten tourniquet. He visited the pediatric ward and first expressed gratitude to all the staff there for submitting the HPSR. He briefly interviewed Sr. Mirembe to ascertain the information reported in the HPSR.

Then Dr. Simon and Sr. Mirembe had a discussion with the mother. They began by introducing themselves, apologizing, and informing her that an investigation would be conducted to identify measures that can be put in place to prevent a similar occurrence onward.

They then asked several questions about the circumstances when the mother discovered the incident. After she answered, the mother requested that they inform families whenever something goes wrong again.

After the initial assessment, Dr. Simon judged the incident to be of low severity since the function of the arm was temporarily affected by the incident and fully recovered with minor medical interventions, but the risk was relatively high since it could lead to disability or amputation. He recommended that Sr. Mirembe and WIT should investigate and analyze the case, which she agreed to as a WIT leader.

5 Analysis and Investigation

Sr. Mirembe interviewed Afiya and Priscilla separately the next day, with support from Dr. Simon and a WIT member.

Afiya recounted her morning, describing how rushed and confused she felt. She had followed the pediatrician's instructions to draw Brian's blood, but she was immediately called by the mother of a patient whose canula had pulled out. This unexpected call delayed her medication duties. She also explained that she applied the glove instead of a tourniquet, which was not available, under Brian's sleeve.

Priscilla also shared her experiences, describing how busy the ward was. She was receiving a handover from the emergency department for two new admissions first thing in the morning, and could not support Afiya's duties, she said.

Sr. Mirembe and members of the WIT conducted a quick survey among the staff in the pediatric ward to ask about tourniquet use. The findings revealed that most of the staff had experienced forgetting to remove a tourniquet on time. The possible reasons cited were: failure to follow procedures; staff distractions and interruptions; inexperienced staff; communication problems between staff; and the tourniquet being covered by other items (e.g., sleeve). Additionally, a lack of patient/family understanding was pointed out. They also explained that they usually applied the tourniquet by pushing up the sleeve, which led to the tourniquet being hidden by the sleeve.

6 Action

From the gathered information, WIT established three rules to prevent recurrence. The first one is to adhere to basic procedures. Standard operating procedures (SOPs) were created by the WIT for blood sampling and cannulation. In the SOPs, it was emphasized that the tourniquet should be released promptly when blood flows into the tube, after advancing the IV catheter, or before withdrawing the needle.

The second rule is that the tourniquet should be applied over the sleeve, or the sleeve should be rolled up rather than pushed up to make it more visible.

Lastly, whenever the staff is interrupted during blood taking or cannulation, they must ensure they remove the tourniquet before leaving the bedside. To seek cooperation from the family and attendants, it was also decided to carefully explain to them what they should watch during the patient handling process.

Sr. Mirembe shared these rules with everyone at the department meeting and insisted that every single one should follow them. She also filled in the

small KAIZEN form to keep their activity records.

6 Learning

Sr. Mirembe met Dr. Simon after the investigation was completed when he visited the pediatric ward for internal supervision. She reported the findings of their analysis and recommendations to him, and he promised to share this case as a good practice with the senior management at the QIT meeting. She then met with Afiya and asked if she was experiencing any distress and required any further support. Afiya appreciated the offer of help, but she did not need any further assistance. She mentioned that the SOPs developed have been very helpful, and she is gradually getting used to working in the Pediatric ward.

Sr. Mirembe also met Brian and his mother when he visited as an outpatient. She summarized the investigation's findings and recommendations. The mother was satisfied that the hospital had taken the matter seriously, investigated thoroughly, and implemented the recommendations so that a similar incident was unlikely to happen again. She then secretly told Sr. Mirembe that there was one patient in her village whose arm had a disability due to a forgotten tourniquet, and she had feared that.

After Dr. Simon reported this case to the senior management during the QIT meeting, it was recognized as a cross-cutting issue affecting other departments. To prevent similar incidents, the management decided to incorporate the recommendations throughout the hospital. All employees were subsequently informed about this at the morning assembly and through official notice.

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10 Appendix

Appendix1: WHO Classification of Patient Safety Incidents (examples in Uganda)

Description	WHO Classification
A patient presented HIV-positive results, but a confirmatory test was conducted before starting treatment, revealing a discrepancy.	Near Miss
An X-ray was requested for the right limb, but radiographer confirmed with the patient that the left limb was actually injured, and corrected the error.	Near Miss
A doctor prescribed and dispensed the wrong medication, but the patient did not take it.	No Harm Event
A student received matched blood, which was mistakenly given to another patient, but the blood was compatible.	No Harm Event
Diclofenac IM was administered instead of oxytocin IM, but no adverse effects were observed.	No Harm Event
A patient was transfused with blood that had been intended for another patient with a different blood group.	Harmful Event
Laboratory results were mistakenly handed to a different patient with a similar name, leading to incorrect treatment.	Harmful Event
A surgeon performed surgery on the wrong limb due to incorrect X-ray films being provided.	Harmful Event

Appendix 2: HPSR form

Patient Safety
5S-KAIZEN-TQM

Health Facility Patient Safety Report

1. Your Cadre ✓*Please select ONE.*	☐ 1. Medical doctor ☐ 2. Nurse/Midwife ☐ 3. Pharmacist ☐ 4. Allied health professional ☐ 5. Intern/Trainee ☐ 6. Administrative staff ☐ 7. Engineer or workshop staff ☐ 8. Support staff
2. Your department/unit ✓*Please select ONE.*	☐ 1. Administration and management ☐ 2. Surgical unit ☐ 3. Medical unit ☐ 4. OBGY ☐ 5. Paediatrics ☐ 6.Casualty and OPD ☐ 7. Operating theatre ☐ 8. Laboratory ☐ 9. ICU/HDU ☐ 10. NICU ☐ 11. Radiology ☐ 12. Occupational Therapy/Physiotherapy ☐ 13. Orthopaedic ☐ 14. Dental unit ☐ 15. Endoscopy/Colonoscopy ☐ 16. Eye unit ☐ 17. Mental unit ☐ 18. Pharmacy ☐ 19. Store ☐ 20. Maintenance workshop ☐ 21. Laundry ☐ 22. Kitchen/Canteen ☐ 23. Other

3. Date of occurrence	/ /
4. Timeframe of occurrence	☐ 1. Day ☐ 2. Evening ☐ 3. Night
5. Location of occurrence ✓*Please select the most relevant ONE.*	☐ 1. OPD ☐ 2. Casualty ☐ 3. Theatre ☐ 4. Delivery room ☐ 5. Ward ☐ 6. ICU ☐ 7. NICU ☐ 8. Pharmacy ☐ 9. Laboratory ☐ 10. Washroom ☐ 11. Corridor/Stairs/hallway ☐ 12. Workshop ☐ 13. Others (inside) ☐ 14. Others (outside)
6. Who was harmed/about to be harmed?	☐ 1. Patient(s) ☐ 2. Hospital staff ☐ 3. Others
7. Category that the event is related to ✓*Please select the most relevant ONE.*	☐ 1. Medication ☐ 2. HCAI (Health care-associated infection) ☐ 3. Anesthesia ☐ 4. Surgical/invasive care ☐ 5. Blood transfusion ☐ 6. Diagnostics ☐ 7. Handover process ☐ 8. Laboratory ☐ 9. Fall ☐ 10. Documentation ☐ 11. Other medical services ☐ 12. Other non-medical services ☐ 13. Physicalenvironment

S/N

8. Description of Near miss/incidents	*Please describe what happened or what you observed.*

9. Possible causes	*What do you think caused the near miss/incident?*

10. Countermeasures	*What do you think should be done to prevent the reoccurrence? Or have you taken any countermeasures to prevent it? (if any)*

Thank you for your cooperation and efforts to improve patient safety!

FOR OFFICIAL USE ONLY

A. Measures taken

☐ 1. Full-scale KAIZEN has been started/will be started soon.

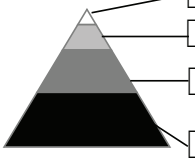
☐ 2. Small KAIZEN has been done.

☐ 3. Other measures have already taken.

☐ 4. Follow up required by the department/unit/WIT.

☐ 5. Support required by QI committee/Management

B. Classification of the event



☐ 1. Harmful incident: An incident that results in harm to a patient.

☐ 2. No harm incident: One in which an event reached a patient, but no discernable harm resulted.

☐ 3. Near miss: An event or situation that could have resulted into harm but did not.

☐ 4. Unsafe environment, unsafe situation

Appendix 3: HPSR form (Examples)

Example 1

Patient Safety
5S-KAIZEN-TQM

Health Facility Patient Safety Report

1. Your Cadre ✓Please select ONE.	☐ 1. Medical doctor ☑ 2. Nurse/Midwife ☐ 3. Pharmacist ☐ 4. Allied health professional ☐ 5. Intern/Trainee ☐ 6. Administrative staff ☐ 7. Engineer or workshop staff ☐ 8. Support staff
2. Your department/unit ✓Please select ONE.	☐ 1. Administration and management ☐ 2. Surgical unit ☐ 3. Medical unit ☑ 4. OBGY ☐ 5. Paediatrics ☐ 6.Casualty and OPD ☐ 7. Operating theatre ☐ 8. Laboratory ☐ 9. ICU/HDU ☐ 10. NICU ☐ 11. Radiology ☐ 12. Occupational Therapy/Physiotherapy ☐ 13. Orthopaedic ☐ 14. Dental unit ☐ 15. Endoscopy/Colonoscopy ☐ 16. Eye unit ☐ 17. Mental unit ☐ 18. Pharmacy ☐ 19. Store ☐ 20. Maintenance workshop ☐ 21. Laundry ☐ 22. Kitchen/Canteen ☐ 23. Other

3. Date of occurrence	5 / 6 / 2025
4. Timeframe of occurrence	☑ 1. Day ☐ 2. Evening ☐ 3. Night
5. Location of occurrence ✓Please select the most relevant ONE.	☐ 1. OPD ☐ 2. Casualty ☐ 3. Theatre ☐ 4. Delivery room ☑ 5. Ward ☐ 6. ICU ☐ 7. NICU ☐ 8. Pharmacy ☐ 9. Laboratory ☐ 10. Washroom ☐ 11. Corridor/Stairs/hallway ☐ 12. Workshop ☐ 13. Others (inside) ☐ 14. Others (outside)
6. Who was harmed/about to be harmed?	☑ 1. Patient(s) ☐ 2. Hospital staff ☐ 3. Others
7. Category that the event is related to ✓Please select the most relevant ONE.	☑ 1. Medication ☐ 2. HCAI (Health care-associated infection) ☐ 3. Anesthesia ☐ 4. Surgical/invasive care ☐ 5. Blood transfusion ☐ 6. Diagnostics ☐ 7. Handover process ☐ 8. Laboratory ☐ 9. Fall ☐ 10. Documentation ☐ 11. Other medical services ☐ 12. Other non-medical services ☐ 13. Physicalenvironment

S/N

8. Description of Near miss/incidents	*Please describe what happened or what you observed.*

Over dose of dexamethason was given to the patient.

9. Possible causes	*What do you think caused the near miss/incident?*

We didn't know the patient was prescribed devamethason at different dipartment.

10. Countermeasures	*What do you think should be done to prevent the reoccurrence? Or have you taken any countermeasures to prevent it? (if any)*

In-patient pharmacy to cross-check the prescription.

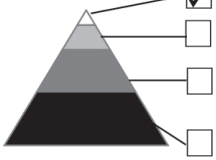
Thank you for your cooperation and efforts to improve patient safety!

FOR OFFICIAL USE ONLY

A. Measures taken

- ☐ 1. Full-scale KAIZEN has been started/will be started soon.
- ☐ 2. Small KAIZEN has been done.
- ☑ 3. Other measures have already taken.
- ☐ 4. Follow up required by the department/unit/WIT.
- ☐ 5. Support required by QI committee/hospital management

B. Classification of the event



- ☑ 1. Harmful incident: An incident that results in harm to a patient.
- ☐ 2. No harm incident: One in which an event reached a patient, but no discernable harm resulted.
- ☐ 3. Near miss: An event or situation that could have resulted into harm but did not.
- ☐ 4. Unsafe environment, unsafe situation

Example 2

Patient Safety
5S-KAIZEN-TQM

Health Facility Patient Safety Report

1. Your Cadre ✓*Please select ONE.*	☐ 1. Medical doctor ☑ 2. Nurse/Midwife ☐ 3. Pharmacist ☐ 4. Allied health professional ☐ 5. Intern/Trainee ☐ 6. Administrative staff ☐ 7. Engineer or workshop staff ☐ 8. Support staff
2. Your department/unit ✓*Please select ONE.*	☐ 1. Administration and management ☐ 2. Surgical unit ☐ 3. Medical unit ☑ 4. OBGY ☐ 5. Paediatrics ☐ 6.Casualty and OPD ☐ 7. Operating theatre ☐ 8. Laboratory ☐ 9. ICU/HDU ☐ 10. NICU ☐ 11. Radiology ☐ 12. Occupational Therapy/Physiotherapy ☐ 13. Orthopaedic ☐ 14. Dental unit ☐ 15. Endoscopy/Colonoscopy ☐ 16. Eye unit ☐ 17. Mental unit ☐ 18. Pharmacy ☐ 19. Store ☐ 20. Maintenance workshop ☐ 21. Laundry ☐ 22. Kitchen/Canteen ☐ 23. Other

3. Date of occurrence	5 / 4 / 2025
4. Timeframe of occurrence	☑ 1. Day ☐ 2. Evening ☐ 3. Night
5. Location of occurrence ✓*Please select the most relevant ONE.*	☑ 1. OPD ☐ 2. Casualty ☐ 3. Theatre ☐ 4. Delivery room ☐ 5. Ward ☐ 6. ICU ☐ 7. NICU ☐ 8. Pharmacy ☐ 9. Laboratory ☐ 10. Washroom ☐ 11. Corridor/Stairs/hallway ☐ 12. Workshop ☐ 13. Others (inside) ☐ 14. Others (outside)
6. Who was harmed/about to be harmed?	☑ 1. Patient(s) ☐ 2. Hospital staff ☐ 3. Others
7. Category that the event is related to ✓*Please select the most relevant ONE.*	☐ 1. Medication ☑ 2. HCAI (Health care-associated infection) ☐ 3. Anesthesia ☐ 4. Surgical/invasive care ☐ 5. Blood transfusion ☐ 6. Diagnostics ☐ 7. Handover process ☐ 8. Laboratory ☐ 9. Fall ☐ 10. Documentation ☐ 11. Other medical services ☐ 12. Other non-medical services ☐ 13. Physicalenvironment

S/N **56**

8. Description of Near miss/incidents *Please describe what happened or what you observed.*

A mother who had a cesarean section returned for a follow-up visit on the 5th day with a significant amount of pus coming from her incision site.

9. Possible causes *What do you think caused the near miss/incident?*

A possible cause could be a lack of proper aseptic technique during her care in the hospital.

10. Countermeasures *What do you think should be done to prevent the reoccurrence? Or have you taken any countermeasures to prevent it? (if any)*

Strict adherence to aseptic technique during all surgical and post-operative care is essential. Proper wound care protocols and monitoring of infection control practices should be implemented.

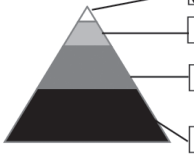
Thank you for your cooperation and efforts to improve patient safety!

FOR OFFICIAL USE ONLY

A. Measures taken

- ☐ 1. Full-scale KAIZEN has been started/will be started soon.
- ☑ 2. Small KAIZEN has been done.
- ☐ 3. Other measures have already taken.
- ☐ 4. Follow up required by the department/unit/WIT.
- ☐ 5. Support required by QI committee/hospital management

B. Classification of the event



- ☑ 1. Harmful incident: An incident that results in harm to a patient.
- ☐ 2. No harm incident: One in which an event reached a patient, but no discernable harm resulted.
- ☐ 3. Near miss: An event or situation that could have resulted into harm but did not.
- ☐ 4. Unsafe environment, unsafe situation

Example 3

Patient Safety
5S-KAIZEN-TQM

Health Facility Patient Safety Report

1. Your Cadre ✓*Please select ONE.*	☐ 1. Medical doctor ☑ 2. Nurse/Midwife ☐ 3. Pharmacist ☐ 4. Allied health professional ☐ 5. Intern/Trainee ☐ 6. Administrative staff ☐ 7. Engineer or workshop staff ☐ 8. Support staff
2. Your department/unit ✓*Please select ONE.*	☐ 1. Administration and management ☐ 2. Surgical unit ☐ 3. Medical unit ☐ 4. OBGY ☐ 5. Paediatrics ☑ 6.Casualty and OPD ☐ 7. Operating theatre ☐ 8. Laboratory ☐ 9. ICU/HDU ☐ 10. NICU ☐ 11. Radiology ☐ 12. Occupational Therapy/Physiotherapy ☐ 13. Orthopaedic ☐ 14. Dental unit ☐ 15. Endoscopy/Colonoscopy ☐ 16. Eye unit ☐ 17. Mental unit ☐ 18. Pharmacy ☐ 19. Store ☐ 20. Maintenance workshop ☐ 21. Laundry ☐ 22. Kitchen/Canteen ☐ 23. Other

3. Date of occurrence	9 / 2 / 2025
4. Timeframe of occurrence	☑ 1. Day ☐ 2. Evening ☐ 3. Night
5. Location of occurrence ✓*Please select the most relevant ONE.*	☐ 1. OPD ☑ 2. Casualty ☐ 3. Theatre ☐ 4. Delivery room ☐ 5. Ward ☐ 6. ICU ☐ 7. NICU ☐ 8. Pharmacy ☐ 9. Laboratory ☐ 10. Washroom ☐ 11. Corridor/Stairs/hallway ☐ 12. Workshop ☐ 13. Others (inside) ☐ 14. Others (outside)
6. Who was harmed/about to be harmed?	☑ 1. Patient(s) ☐ 2. Hospital staff ☐ 3. Others
7. Category that the event is related to ✓*Please select the most relevant ONE.*	☐ 1. Medication ☐ 2. HCAI (Health care-associated infection) ☐ 3. Anesthesia ☐ 4. Surgical/invasive care ☑ 5. Blood transfusion ☐ 6. Diagnostics ☐ 7. Handover process ☐ 8. Laboratory ☐ 9. Fall ☐ 10. Documentation ☐ 11. Other medical services ☐ 12. Other non-medical services ☐ 13. Physicalenvironment

S/N **72**

8. Description of Near miss/incidents *Please describe what happened or what you observed.*

The student nurse was about to administer an unlabelled unit of blood to a patient.

9. Possible causes *What do you think caused the near miss/incident?*

A lack of proper labeling procedure to follow protocol during blood handling and patient.

10. Countermeasures *What do you think should be done to prevent the reoccurrence? Or have you taken any countermeasures to prevent it? (if any)*

Ensure that all blood samples are labeled correctly and clearly with patient identification before being transported.

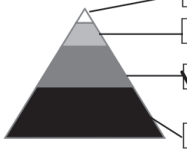
Thank you for your cooperation and efforts to improve patient safety!

FOR OFFICIAL USE ONLY

A. Measures taken

- ☐ 1. Full-scale KAIZEN has been started/will be started soon.
- ☐ 2. Small KAIZEN has been done.
- ☑ 3. Other measures have already taken.
- ☐ 4. Follow up required by the department/unit/WIT.
- ☐ 5. Support required by QI committee/hospital management

B. Classification of the event

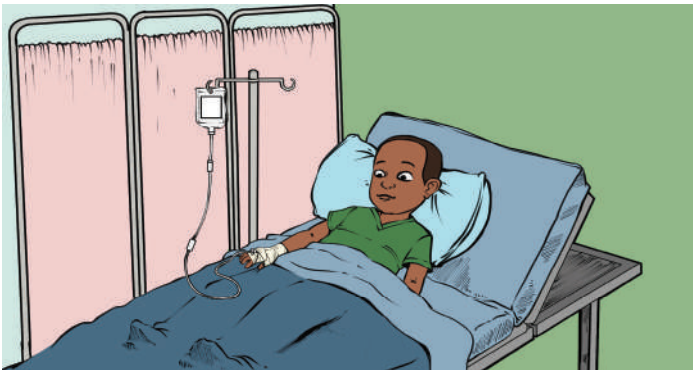


- ☐ 1. Harmful incident: An incident that results in harm to a patient.
- ☐ 2. No harm incident: One in which an event reached a patient, but no discernable harm resulted.
- ☑ 3. Near miss: An event or situation that could have resulted into harm but did not.
- ☐ 4. Unsafe environment, unsafe situation

Appendix 4: Example of KAIZEN and HPSR

Case: Catheter failures at a Paediatric Ward

Step 1: Theme selection



Hello, my name is Agnes. I'm a nurse working for a paediatric ward at ABC regional hospital. I'm also a member of the WIT, the work improvement team in this ward.

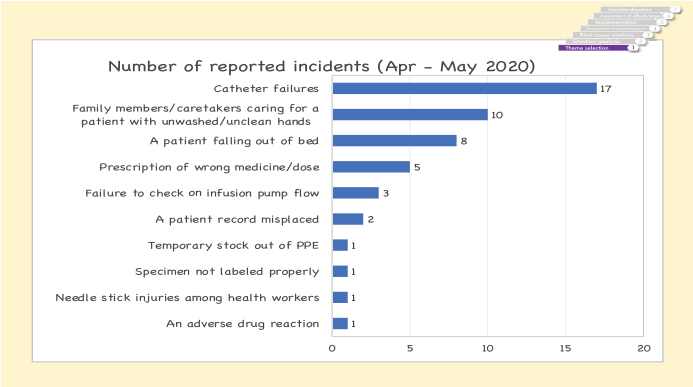
Today, I'm going to share our experience in KAIZEN with you. As you can see from the title, we tackled the issue of catheter failures, which frequently happened in our ward.

Step 1: Theme selection(2)

It all started when we, the WIT members, were reading incident reports during a WIT meeting. We call these incident reports "Health Facility Patient Safety Reports" and make good use of them to prevent the same incidents from happening again.

One day, some of the members noticed that there seemed to be many incidents related to IVs, so we decided to review the reports of the last 2 months and classify the incidents by cause, so that we could compare the number of cases for each cause.

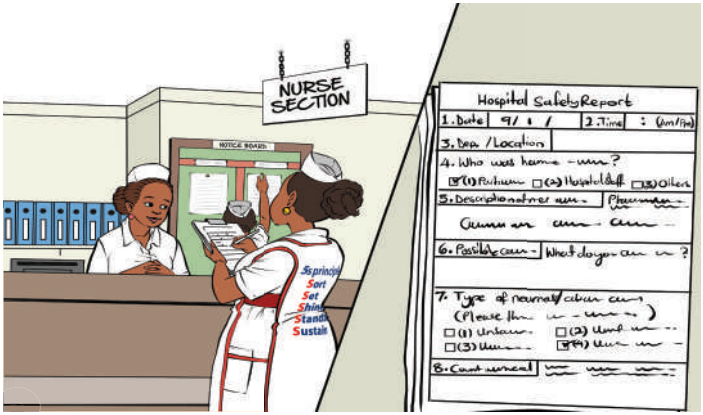
Step 2: Situation analysis



And this is the result of our review: The bar chart shows that catheter failure is the leading cause of incidents in our ward, followed by care given with unwashed hands and falls from the bed.

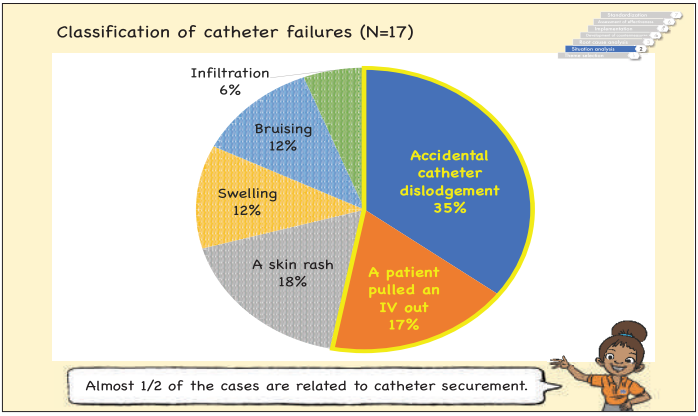
So we decided to take up the issue of catheter failure as the topic of our next KAIZEN activity. We decided that our KAIZEN theme would be “The number of incidents caused by catheter failure is reduced”.

Step 3: Situation analysis (2)



We tried to categorize the total of 17 cases according to the events that occurred, and found out that 49%, almost half of the cases, were related to catheter securement. In all these cases the IV lines were pulled out (accidentally or on purpose), and we suspected that these cases were caused by the catheter not being fixed properly.

Step 3: Situation analysis (3)



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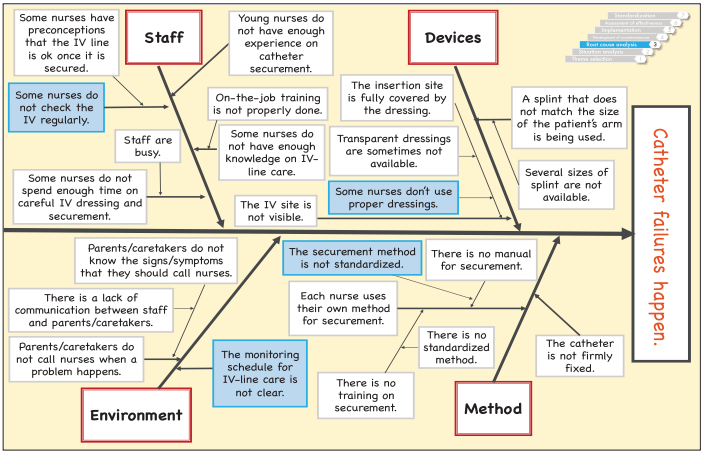
Step 3: Root cause analysis



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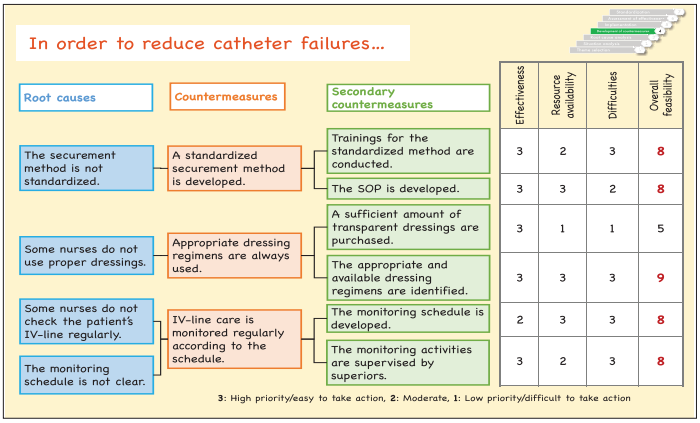
Step 4: Development of countermeasures



For each cause we chose, we came up with countermeasures and described specific activities for each second countermeasure.

Then we scored the feasibility of the second countermeasures from 3 perspectives: effectiveness, resource availability and difficulty. Then, we decided to implement 5 activities that scored high, as the matrix on the right side shows.

Step 5: Implementation

Implementation

Countermeasures	WHY	WHO	WHEN	WHERE	WHAT
1. Implementation of the trainings for the securement method	In order for all the nurses to apply the standardized method	Rose	By 30th Sept.	Paediatric WD	• Prepare the training materials. • Conduct the training in small groups.
2. Development of the SOP for the securement method	To standardize the securement method	Sarah	By 8th Sept.	Nurse station	• Write the procedures and prepare the photos. • Print and display them.
3. Identification of the appropriate and available dressing regimens	In order for all the nurses to always use the suitable dressings	Agnes	By 20th Aug.	The dressing room	• Check the available dressings. • Discuss and identify the suitable dressing regimens.
4. Development of the monitoring schedule for the patients' IV-line	To monitor the patients' IV-line regularly	Alison	By 31st Aug.	Nurse station	• Decide on the timing of the monitoring. • Allocate staff to the monitoring schedule.
5. Supervision of monitoring activities	To have monitoring activities done as planned	SNO	Daily	Paediatric WD	• Check the roster and supervise IV-line care.

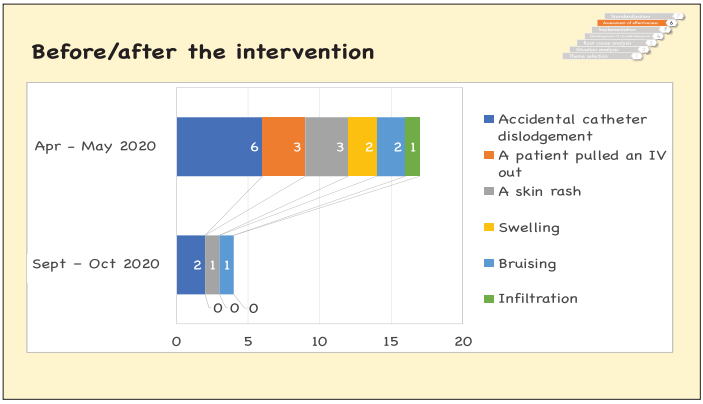
We had a discussion and made this action plan. For each activity, there is a person in charge and a deadline. I was put in charge of number 3,"Identification of the appropriate and available dressing regimens". What I had to do was to check the available dressings in the dressing room and identify the suitable dressing regimens through discussion with my colleagues, so that all the nurses would always be able use the suitable dressings.

Step 5: Implementation (2)

My colleague, Rose, was in charge of the trainings for the securement method. After Sarah and the team had completed the SOP for the securement method, Rose prepared the training materials and organized several training sessions in small groups, in accordance with the SOP.

She demonstrated the standardized securement method and explained why all staff need to utilise the method.

Step 6: Assessment of effectiveness



After all the countermeasures were taken, we assessed their effectiveness. In order to compare the data, we counted the number of IV-related incidents that happened in a subsequent 2-month period. As the bar chart shows, the number of incidents due to accidental catheter dislodgement decreased from 6 to 2, and not a single incident of a patient pulling out an IV occurred during this period.

As a result, the overall number of incidents related to IVs also decreased. So we concluded that the measures we took were effective and commended ourselves for our efforts!

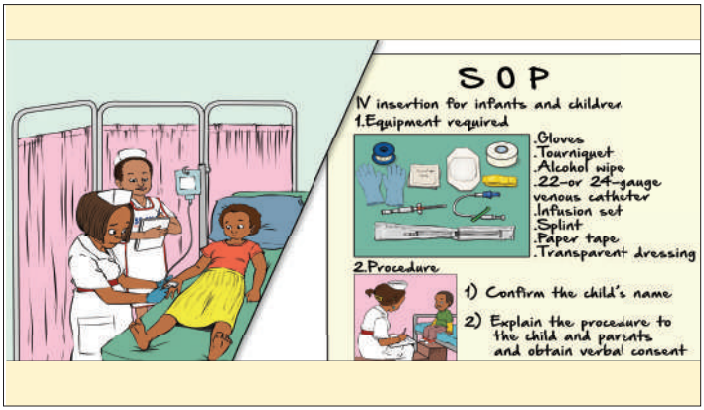
Step 7: Standardization

Standardization

	WHY	WHO	WHEN	WHERE	WHAT
SOP	To standardize the securement method for infants and children at the entire hospital	The team	By the end of the year	OPD, Theatre, Casualty	Print and distribute the SOPs to the 3 departments.
Trainings for the securement method	To teach the standardized method to new staff	The team	New nurses are allocated.	Paediatric WD	Teach the method through on-the-job trainings.
Monitoring (1) Supervision	To have the patients' IV-line monitored regularly	SNO	Daily	Paediatric WD	Supervise the IV-line monitoring done by nurses.
Monitoring (2) Hospital safety reports	To be proactive toward catheter failure	The team and QIT	Every 3 months	QIT office	Review the hospital safety reports and analyse them if incidents related to catheter failure are reported.

Continual efforts will be needed to keep IV-related incidents low. We also found that the cooperation of other departments that accept and treat children and infants was essential. In order to sustain the improved situation and prevent recurrence, we developed this standardization plan.

Step 7: Standardization (2)



We talked to the WIT leaders in the OPD, theatre and casualty, and shared the SOP for the securement method so that they could apply the standardized method.

Also, the training for new nurses was ongoing at the time of allocation, as well as monitoring through supervision and reviewing the Health Facility Patient Safety Reports. This is the full scope of our KAIZEN project. I hope you find it helpful!

Patient Safety
5S-KAIZEN-TQM

JICA