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Nurses' perspective on the management of adverse events in primary healthcare clinics

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Abstract

The main aim of the study was to explore the reasons why nurses fail to implement the available laid down procedures of dealing with adverse events. The quantitative research methodology was applied to reach the purposes of the study. The authors found that as much as nurses are orientated on the policy of adverse events management, there is no ongoing training on the management of adverse events. Furthermore, the study found that staff is not included in the planning on the management of adverse events and the adverse events management committees are not fully representative of all categories of staff.

Keywords: adverse, nurses, events, clinical, healthcare.

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Perspectiva de las enfermeras sobre el manejo de los eventos adversos en las clínicas de atención primaria

Resumen

El objetivo principal del estudio fue explorar las razones por las cuales las enfermeras no implementan los procedimientos disponibles establecidos para tratar los eventos adversos. La metodología de investigación cuantitativa se aplicó para alcanzar los propósitos del estudio. Los autores encontraron que, al igual que las enfermeras están orientadas en la política de gestión de eventos adversos, no hay capacitación continua sobre el manejo de los eventos adversos. Además, el estudio encontró que el personal no está incluido en la planificación del manejo de eventos adversos y que los comités de gestión de eventos adversos no son totalmente representativos de todas las categorías de personal.

Palabras clave: adversas, enfermeras, eventos, clínica, cuidado de la salud.

1. INTRODUCTION

This paper is a product of a research work on the management of adverse events in the primary healthcare clinics in the UMgungundlovu Health District. Many health institutions and authors have provided the definition of adverse events. For example, Bartlett et al.(2008) argued that an adverse event is an unintended injury or

complication caused by delivery of clinical care rather than by the patient's condition and the World Health Organization (WHO)Conceptual Framework for the International Classification for Patient Safety (2009) defines an adverse event as aninjury that resulted in harm following medical care that would lead to the patient being hospitalized for a longer period or being subjected to some form of¿ disability. The overall objective of this study was to explore the reasons for not implementing available adverse event management procedures. Other objectives among others included investigating the reasons for failure to identify, report and manage adverse events, interrogating the available documents' ability to assist in adverse event management, evaluating the existing information management systems in the management of adverse event management, and evaluating existing improvement plan in place on adverse events management.

2. BACKGROUND OF THE STUDY AND LITERATURE REVIEW

According to the Strategic Plan 2015-2019 (2015), the functions of the KwaZulu-Natal Department of Health are structured in the form of eight programs, namely, Administration, District Health Services, Emergency Medical Services, Regional and Specialized Hospitals, Tertiary Central Hospitals, Health Sciences and Training, Health Care Support Services and Health Facilities Management. The Primary health clinics fall under Program two, which is the District Health Services. These primary healthcare clinics are divided into three

categories, namely Category A, B and C. These categories are based on the size of the population being serviced and hours of operations. Category A, offers healthcare services to a population of about 8 000 people, eight hours a day for five times a week. Category B clinics render healthcare services to a population of 12 000 people for 12 hours, seven days a week. Category C offers services to a population of 20 000 people, 24 hours a day for seven days a week.

The Constitution of the Republic of South Africa, no 108 of 1996:1247 Section 24, subsection (a) advocates for a right to a harm-free environment for the benefit of the citizens' health and wellbeing. Section 195 requires a public administration that maintains high standards of professional ethics, delivery services that are fair, impartial and responsive to people's needs, and provides the public with accurate information with accountability. According to the KZN Department of Health Annual Performance Plan (2014/15-2016/17:21), 38,7% of the mortality rate of children under the age of five occurred outside health facilities, 56,5% occurred in the district hospitals. 2.6 % died on arrival, 31,5% occur within 24 hours of admission and further, 25,7% occur between first and second day, overall 57,2% die within 72 hours of admission most causes being pneumonia and diarrhea. Different authors such as Bartlett et al. (2008), argue that up to 50% of these are preventable and that up to 17% of hospitalized patients are adverse events.

Types of adverse events: According to the World Health Organization Conceptual Framework for the International

Classification for Patient Safety (2009), incidents that are viewed as adverse events can be classified into thirteen types. For example, clinical administration incidents which occur when processes can cause harm to the patient, for example a long wait before a patient is attended to, clinical procedure related incidents which are incidents that occur as a result of an incorrect diagnosis or a wrong procedure being performed or not performed at all, and healthcare associated infections, which are incidents that occur as a result of patients acquiring bacteria or virus causing infection other than the problem that the patient came to be treated for. These are just a few examples to mention.

Adverse Events Management: According to Cronje et al.(2009), management is a process, carried out through task planning, organizing, leading and control to achieve organizational goals. Furthermore, the authors state that the process is about utilization of resources, whether human, financial, information and physical to achieve an organizational goal. It can therefore be deduced that with adverse event management, the goal is to reduce harm to patients caused by adverse events through the tasks of management. The UMgungundlovu Health District Adverse Events Policy and Reporting System (2012) states that adverse event management is about investigating, analyzing and reporting on the adverse events according to the prescribed format.

According to Wetzels et al. (2009) adverse events have been associated with hospital care so much that it is unclear as to what extent they cause harm to the primary healthcare environment. The

authors did a study in the Netherlands to determine actual or potential harm of adverse events in primary healthcare. The authors used categories like errors in office administration, errors in diagnosis, treatment errors and communication errors. According Wetzels et al. (2009), errors that were found to be common in administration were the absence of recorded diagnosis, patient sharing the same name not clearly identified and a home visit made to the wrong patient, as well as failure to refer a patient to hospital. The authors further stated that errors in diagnosis identified were administering antibiotics without a patient being thoroughly examined. With regards to treatment errors, a patient was given penicillin when penicillin allergy was recorded in the patient record, in another case a patient could not be followed up because of the doctor was on holiday. Wetzels et al. (2009) state that in terms of communication errors, gaps were identified between doctors and other institution, and between doctors and patients. For example, there was a case where the doctor's failure to communicate to the patient to report to the hospital in two days for continuity of care resulted in the patient losing the unborn baby. The authors argue that the fact that doctors are the ones doing self-registration of adverse events implied that the results were mainly subjective hence the medical records did not provide all relevant information on events. The authors further argue that methods employed in hospitals to manage adverse events cannot be transferable to the primary care setting. According to Wetzels et al. (2009)adverse events in primary care are frequent and posea low risk for serious harm to patients, therefore a conservative approach to patient safety in primary care is

recommended to handle low risk. Wetzels et al. (2009) are of the opinion that the initiatives implemented to improve patient safety in primary care should not focus on harm, as actual harm is not useful to measure effectiveness of patient safety interventions. The authors recommend a comprehensive approach whereby unnecessary lengthening or worsening of clinical symptoms is prevented.

Morimoto et al. (2015) state that according to Baker et al. (2002), the most reliable method of detecting errors of the medication in the in-patient, especially with errors due to medication, is through direct observation. Morimoto et al. (2015) suggested using the three methods of collecting data on drug-related events to complement each other, namely the practice data, self-report by the health professional and patient surveys. The authors state that a third to half of adverse drug events are associated with medication errors. According to Fischbacher-Smith and Fischbacher-Smith (2009), organizations should use the reports on near misses as a learning experience and to prevent future occurrence of adverse events. Furthermore, the authors argue that identifying the root cause in the occurrence of adverse events can assist in drawing lessons from that.

Mattox (2012) states that an error occurs when the planned activities produce unintended results. Furthermore, the author state that it is either the plan was not executed as intended or the plan was inadequate. Mattox (2012) argues further that patients can be subjected to harm not because there was an error in the execution of duties, citing an example of a patient developing a lung injury following blood

transfusion from an appropriately matched blood product. The author notes that harm due to negligence, reckless or criminal activities should not be termed an error resulting from healthcare. According to Mattox (2012), there are different types of errors, namely, skills-based, rule-based and knowledge-based. The author identifies skills-based errors as slips and lapses, the former being resultant of attention deficit and the latter due to memory failure. The author argues that prevention of skill-based errors are difficult, since retraining on skills based tasks seems to show little impact. The author further argues that other contributing factors should be taken into consideration like the environmental surroundings or individual distractions like stressors. According to Mattox (2012), mistakes occur when the proposed plan is inadequate to achieve the intended goal. The author categorizes the rule-based and the knowledge-based errors as mistakes. The author argues that the rule-based error involves the application of rules or protocols based on practical experience, but with adverse consequences, citing an example of giving a drug, according to protocol not knowing that the drug has already been given to the patient since there was no recording of such activity, resulting in complications or even death of a patient. According to Mattox (2012), knowledge-based error refers to behavior that occurs when the healthcare worker is in a situation where the rule-based and the skill-based action seem not to be applicable. The healthcare worker develops his or her own mental model how to solve the problem at hand resulting in harming the patient.

Mattox (2012) provides an error management strategy described as measures that are instituted to reduce or contain errors. The author states that with the error reduction strategy, there are different approaches that can be implemented, like empowering of patients with the necessary knowledge on their safety, inculcating a culture of safety amongst healthcare workers as well as use of standardized processes, which can be in the form of checklists that can reduce skill-based errors. Mattox (2012) states that the error containment strategy is about using previous errors and developing plans to reduce future errors, which can be done by developing algorithms for the management of clinical conditions. According to McCulloch et al. (2010), in their study to assess the risks involved with surgical patients, the most common causes of adverse events are delays in investigating and offering management care to the patient's presenting problem followed by the readmissions due to inappropriate management.

According to Kelly (2010), Florence Nightingale discovered that lack of cleanliness and hand washing was linked to patient adverse outcomes. The author further cited a report by Jarvis (2007) who stated that the lack of adherence to hand washing by healthcare providers resulted in 2 million hospital-acquired infections, 90 000 deaths, and burden the cost of healthcare went up to $29 billion annually.

Reporting of adverse events: World Health Organization's Conceptual Framework for the International Classification for Patient Safety (2009) describes an incident reporting as the documentation of occurrences on a patient under the healthcare professional.

Furthermore, the document describes an incident reporting as a system for collecting and reporting adverse events due to medication and equipment failures. The document states that the reporting offers limited information because the individual reporting fears punitive actions. According to Heideveld-Chavalking et al. (2014), incident reporting is not happening an opinion supported by Wetzels et al. (2009), whose study found that doctors managed to report 20 out of 31 incidents, the remaining 11 were only detected by the researchers when they were conducting the study. The authors then concluded that this poor reporting attitude puts patients at risk of harm as the study revealed that six out of ten were likely to be exposed to harm, eight out of ten will have their medical condition worsened due to adverse events. According to Richter et al. (2014), in studies that were conducted in the United States and the United Kingdom, 96% of errors are unreported. The study found that in hospitals that have adopted electronic incident reporting, only 10% is captured. Based on the above figures it can be deduced that electronic incident reporting requires staff commitment for it to succeed. Heideveld-Chavalking et al. (2014) mention several reasons for failure to report incidents, namely clinical factors, time constraints and policies to mention just a few. The clinical factors can interfere with reporting as the priority of the healthcare worker is to save life, for example, in an emergency situation before reporting on the incident the healthcare worker may be required to attend to another emergency. Heideveld-Chavalking et al. (2014) argue further that in busy clinical areas time constraints could be one of the reasons. The author argues further that that staff members at times are

unfamiliar with the reporting system and that too could be one of the reasons for not reporting the incidents. Furthermore, the authors state that the other reason for not reporting adverse events is the lack of policy that promotes reporting and prevents staff from looking at it in a punitive sense thus encouraging them to report adverse events. Heideveld-Chavalking et al. (2014) argue that due to lack of reporting, the incident reporting cannot be used as a monitoring and evaluating strategy, but can be useful to identify areas requiring priority attention.

According to Fischbacher-Smith and Fischbacher-Smith (2009), the United Kingdom Department of Health, in 1998, started to publish mortality rates as a strategy to alleviate public concerns against the medical mistakes and the performance of institutions. The authors are of the opinion that concentrating on the underlying causes of the adverse events will decrease the burden on cost and improve the trust the public has on healthcare.

Fischbacher-Smith and Fischbacher-Smith (2009) argue that there are several ways of generating errors. Firstly, it is the problem solving and the disclosure of diagnosis by doctors, which can be a source of error if the information does not make sense to the patient. Secondly, the ambiguity of information provided to the patient can result in an error if the doctor is not caring that the nature of the information that is conveyed to the patient can be damaging. Lastly, the way the doctor communicates a diagnosis to the patient, for example, a case where the patient is denied a two-way communication to ensure that the message in the information is well received and the

patient understands the decision made. This can happen in cases where there are time constraints to discuss the case and in cases where symptoms are described to patients or family members in a misleading manner. According to Provonost (2008), to improve the value of reporting, collected data should be used to identify hazards, identify areas that need priority focus, develop mitigating strategies and monitor the effectiveness of those interventions in reducing harm to the patient. Provonost et al. (2008) highlight other contributing factors to poor reporting, like the lack of clarity on which events are reportable events. For example, a nurse may find an error in the standardized medicine dosage schedule and fail to report it because he or she is whether or not this is a reportable event. Furthermore, the other contributing factor is the uncertainty whether to report any event or the events that are specified in the reporting systems. Provonost et al. (2008) are of the opinion that eliminating harm is the most effective intervention as compared to the weak strategy of developing a policy to eliminate harm. For example, if there is a problem with overdosage with the potassium drug, the best intervention is to remove the drug from the care area and control usage, rather than formulate policy to educate staff.

Problem statement: each Government Departments has a Strategic Plan document in which it states its current situation and proposes ways and means of how current challenges are to be dealt with going forward. Within the KwaZulu-Natal Department of Health, the Strategic Plan document has been able to provide information and statistics about adverse events (AE) that took place within the

Government hospitals.However, no information has been provided about the same issues happening within the clinics of the same Department. The only available information is mainly found in the National Core Standards External Assessment Report published in 2013, which states that nurses seem not to be aware of a variety of issues around adverse event management. The extent to which they lack awareness on such issues is not clearly articulated and no clarity is provided on issues relating to training of nurses, familiarizing them with the policies and guidelines set by the department to report such adverse events. The result is that there is no clear picture of the extent to which adverse events are managed within Primary Health clinics, with particular reference to UMgungundlovu District.

Significance of the study: the study will benefit nurses and managers with the knowledge and skills to deal with adverse event management. The knowledge will contribute to the management of adverse event through improved reporting, thereby reducing associated financial costs. Furthermore the study will show the importance of focussing on both hospitals and primary healthcare facilities in the management of adverse events as opposed to the current one-sided approach.

The main aim of the study was: to explore what makes the clinics fail to manage adverse events as per expected practices. Furthermore, the study aims to create awareness amongst nurses as to the benefits of reporting adverse events. This aim was to be achieved by answering the following research questions:

- To investigate the reasons for failure to identify, report and manage adverse events.
- To interrogate the available documents' ability to assist in adverse event management.
- Toevaluate existing information management systems in the management of adverse event management.
- To investigate the work environment in the management of adverse events.
- To evaluate existing improvement plan in place on adverse events management.

Main research question: Why are health workers unable to implement adverse event management procedures that are in place? Other important research sub-questions include the following:

- What are the reasons for failure to identify, report and manage adverse events?
- To what extent do the available documents assist in the management of adverse events?
- How do the existing information management systems assist in the management of adverse events?
- Does the environment allow for effective adverse event management?
- How effective is the existing improvement plan in the management of adverse events?

Definition of key words: The descriptions of key terms are provided below and are based on the World Health Organization Conceptual Framework for the International Classification for Patient Safety (2009).

Patient safety: patient safety is described as a situation in which the patient is subjected to little or no harm during the process of service delivery. Patients may be subjected to a number of possible harmful situations which health workers are expected to ensure that they are prevented. These among others include fall, misdiagnosis or administration of a wrong drug and so forth.

Near misses: A near miss is described as an incident that nearly occurred, but was unreported since the health worker committing it only knew it or that incident was intercepted before it occurred.

Error: an error is described, as failure to execute planned activities to produce intended outcome or it is merely an execution of an incorrect plan.

Harm: the WHO Conceptual Framework for the International Classification for Patient Safety (2009) describes harm as impairment of the normal physical, psychological or emotional body structure that needs intervention.

Hazard: a hazard is described as a potential cause for harm or a threat to the safety of patients.

Incident: an incident is an event or circumstance that causes an injury or poses a risk or harm to the patient. In actual fact, all the above terms are classified as incidents.

3. RESEARCH DESIGN AND METHODOLOGY

The study was conducted within the 51 Primary Health Care fixed clinics (PHC) in the UMgungundlovu Health District. The UMgungundlovu Health District is situated in Pietermaritzburg, the Capital City of KwaZulu-Natal Province. The population of the study comprised of all the nurses working in the 51 Primary Health Care fixed clinics and was estimated to be 461 in size. The quantitative research methodology was deemed to be the most appropriate for the purposes of the study, especially taking into account the size of both the population and the sample. The sample of the study comprised of 148 nurses and the method that was used to obtain this sample was simple random sampling. A structured self-administered questionnaire comprising of 40 closed questions presented in the form of a Likert scale was used to collect data. The questionnaires were left with each and every operations manager in charge of the clinic who in turn distributed them to his/her staff during weekly meetings. The questionnaires were collected during the month of June in 2015.The Statistical Package for Social Sciences (SPSS) software was used to analyze the data. Internal validity was measured using Cronbach's co-efficient whose value was 0.75 hence the study can be viewed to be having internal validity. In line with the rules as stipulated in the

University of KwaZulu-Natal (UKZN) ethics research policy, the researcher ensured that all the rules were observed. The participants of the study were made aware of who the researcher was and what the study was all about. The participants were informed that participation in the study was voluntary. They were further informed that they could withdraw from the study at any time if they so wished. The participants were also informed that anonymity and confidentiality would be maintained at all times. They were also informed that they would not be given any financial reward for participating in the study. Furthermore, participants were informed about how the data would be stored and eventually destroyed. All other ethical considerations that generally apply in research studies were critically observed.

4. DATA ANALYSIS (DEMOGRAPHIC DATA)

Table 4.1 Frequency table indicating the age of the participants

		Frequency	Percent	Valid Percent	Cumulative Percent
Valid	<30	22	14.9	14.9	14.9
	30-40	55	37.2	37.2	52.0
	40-50	43	29.1	29.1	81.1
	>50	28	18.9	18.9	100.0
	Total	148	100.0	100.0	

The frequency table above indicates the age distribution of participants. Out of 148 participants, 22(14.9%) are below age of 30, 55(37%) are aged between 30 to 40 years, 43 (29.1%) are between 40 to 50 and 28 (18.9%) are above 50 years of age.

Table 4.2. Frequency table indicating the length of service of the participants in years.

Frequency	Percent	Valid Percent	Cumulative Percent
30	20.3	20.3	20.3
51	34.5	34.5	54.7
20	13.5	13.5	68.2
47	31.8	31.8	100.0
148	100.0	100.0	

The frequency table shows the length of service among the participants. 30 (20.3%) participants have worked for less than a year, 51 (34.5%) have worked between one and five years, 20 (13.5%) have worked for five to ten years and 47 (31.8%) have worked more than ten years.

Table 4.3 Frequency table indicating section where participants are allocated

		Frequency	Percent	Valid Percent	Cumulative Percent
Valid	Triage	12	8.1	8.1	8.1
	Well baby clinic	12	8.1	8.1	16.2
	Chronic	24	16.2	16.2	32.4
	HAST clinic	25	16.9	16.9	49.3
	Maternal and child	25	16.9	16.9	66.2
	Minor ailments	32	21.6	21.6	87.8
	Treatment room	11	7.4	7.4	95.3
	Managers office	7	4.7	4.7	100.0
	Total	148	100.0	100.0	

The frequency table shows the distribution of the 148 participants in different sections. 12(8.1%) are working at triage area, 12(8.1%) are allocated in the well-baby clinic, 24(16.2%) are working at the chronic area, 25 (16.9%) are working at the HIV/AIDS/Sexually Transmitted infection and Tuberculosis (HAST) section, 25 (16.9%) are working on the Maternal and child section, 32 (21.6%) are working at the Minor ailments section, 11(7.4%) are allocated at the treatment room and 7 (4.7%) are in Manager's office.

Table.4 Frequency table indicating the role of participants in their sections

		Frequency	Percent	Valid Percent	Cumulative Percent
Valid	Employee	129	87.2	87.2	87.2
	Team Leader	12	8.1	8.1	95.3
	Clinic Supervisor(OM)	7	4.7	4.7	100.0
	Total	148	100.0	100.0	

The frequency table and pie chart show role played by each of the 148 participants. 7 (4.7%) are operational managers, 12(8.1%) are team leaders and 129(87.2%) are employees under supervision.

5. DISCUSSION OF THE RESEARCH FINDINGS

NB: N=Total number of responses out of a sample of 148 respondents

- **What are the reasons for poor adverse event management within UMgungundlovu?**

NB: N=Total number of responses out of a sample of 148 respondents

In answering this research question the researcher posed questions on the questionnaire to assess whether or not the participants agreed to those reasons. This study has proven that there are various elements that are the reasons for poor adverse event management. Firstly, in respect to the lack of training on adverse event management as a cause to poor management of adverse events, the majority of the participants (93.9%: N139) agreed to this opinion. Secondly, the lack of proper patient identification was cited as another reason for poor adverse event management by the majority of participants (97.3%: N144). Thirdly, the tools that are available in the clinics are hospital oriented as confirmed by the majority of the participants (72.3%) and that the classification in the reporting tool is not clearly understood as further confirmed by 70.2% of the participants. Furthermore the majority of participants (95.2%), agreed to the increased workload and lack of teamwork (97.3%) as reasons to poor adverse event management.

It is a requirement by the National Core Standards to conduct periodic quality assessments or audits, as they are popularly known. This study found that audits are not consistently done and feedback is not offered to all staff to ensure that there is an improvement in patient

safety. 54% of the participants agreed that audits had not been conducted and 85.8% agreed to feedback not being formally given to all staff. The clinics are expected to hold daily briefing sessions where issues like patient safety are discussed and this study has proven that this was not being done as the majority of participants (83.8%), attested to that. The fact that the clinics did not have an information management system in place to ensure that data on adverse events is electronically captured to be available for teaching, monitoring and evaluation purposes is one reason for poor adverse event management as agreed to by 87.9% of participants.

The facilities need to improve in having adverse events committees that are fully representative of all categories of staff as per the National Core Standards requirement. Only 52% of participants agreed that clinics had these adverse events management committees and 86.2% of participants believed that these are not fully representative of all categories of staff.

- **Are available documents followed in the management of adverse events?**

Fair amount of staff have been orientated and trained on the adverse events policy, (69.6%: N103), which is commendable. The study showed that training is not an on-going process as participants (81.7% N: 121) were not trained in a six month period. No formal training either on the training programs. If

there are scheduled training most participants are willing to undergo (95.3%: N141).

There is some lack of reporting of adverse events. 59 participants i.e. (39.9%)agreed to have omitted reporting adverse events in the last six-months. This should be worrying that about 40% of participants are not reporting, whichcould be that they missed reporting serious adverse events. The 89(60.1%) participants that are reporting should be commended for doing so.

- **What is the current information management system in place?**

There is a communication on adverse event management as the majority of participants (77% N: 114), are aware of reporting procedures. The study showed that there is no electronic capturing and storage of information on adverse events as the majority of participants agreed to that (82.4%). Capturing information electronically assists in ensuring that data is available for monitoring and evaluation and teaching purposes. There is an organizational structure that the staff knows about and there seem to be no challenge in approaching supervisors for reporting adverse events, it can be said that the reason the 39.9% participants are not reporting can be attributed to the shortcomings of the reporting tools.

- **Does the environment allow for effective adverse events management?**

There is poor planning around adverse event management. The majority of participants (79.7%), agreed to be excluded in the planning and about (83.1%) agreed to not knowing budget allocated to the clinic. The study showed that adverse event management is not included in the Employee Management and Development System (EPMDS) as 60.8% of participants agreed. The staff performance management did not include adverse events as 56.1% of participants agreed that the performance was not fully monitored and 54% agreed that the performance is not evaluated.

Community involvement is not encouraged as the study showed that 76.3% of participants are of the opinion that the clinic committee is not encouraged to report on adverse events management issues and a further 69.6% of participants believe the clinic do not report to the clinic committee on these issues. There are complaints mechanism in place in most facilities, according to 83.8% of participants as well as 84.4% is aware of non-government organizational partnerships. These strategies can be used to assist in ensuring patient safety in clinics.

The study showed that the clinics are not ready for disasters. The majority of participants (83.1%) confirmed that there had been no disaster drills that were conducted in the clinics.

- **What quality improvement plan is in place for the management of adverse events?**

The study showed the unavailability of a quality improvement plan as confirmed by 72.3% of the participants and also that where the plan is available it is not communicated to all staff.

- **Why health workers are unable to implement adverse events management procedures that are in place?**

Based on the answers to the sub-research questions discussed above, it could then be concluded that the main reason why health workers are unable to implement adverse event management procedures that are in place is because there is an insufficient ongoing training of staff on the issues of adverse events. Furthermore, the tools that are available to report on are not user-friendly to allow for staff members to report incidents as they occur in the clinic environment. The study also showed that there is poor planning for adverse events prevention like engaging staff in disaster drills, formulating adverse events management committee and conducting audits on adverse events.

Answer to the main research question: why are health workers unable to implement adverse events management procedures that arein place?

Based on the answers to the sub-research questions discussed above, it could then be concluded that the main reason why health

workers are unable to implement adverse events management procedures that are in place is because there is an insufficient ongoing training of staff on the issues of adverse events. Furthermore, the tools that are available to report on are not user-friendly to allow for staff members to report incidents as they occur in the clinic environment. Furthermore, the study showed that there is poor planning for adverse events prevention like engaging staff in disaster drills, formulating adverse events management committee and conducting audits on adverse events.

6. RECOMMENDATIONS

It is recommended that the adverse event management should be part of all training programs. Adverse events training should be incorporated to the primary healthcare course programs as well as during in-service training programs. Operational Managers must undergo a compulsory training that will equip them with skills in conducting monitoring and evaluation, coordination of programs and strategic planning.

It is recommended that regular sustainable document reviews be implemented to ensure that correct accurate documentation is implemented, that important and critical information is recorded and this used as a learning situation for preventing documentation adverse events. In all documents in which adverse events are identified, there is missing information that limits further investigation.

It is recommended that the performance management of adverse events should not be limited to the quality focal person, but should be part of all healthcare workers so that the culture of patient safety is enforced. It is therefore recommended that the job descriptions be reviewed.

The Celebration of International Patient Safety Day as per the Health Calendar can create a sustainable awareness to patients as well as healthcare workers. Therefore, it is recommended that the International Patient Safety Day should be celebrated on a yearly basis and that this should be a key responsibility area of the district quality manager. In the UMgungundlovu Health District, this day has never been celebrated, even the researcher became aware of its existence during this study.

It is recommended that the reporting tools be primary healthcare orientated. The current reporting tools, which are found in the UMgungundlovu Health District Adverse Events Reporting Policy (2012), are hospital orientated and allow only for the supervisor to do the reporting without offering a template to be used by the healthcare worker. Furthermore, the monthly summary is hospital orientated and does not allow for a reporting person to clarify and distinguish death and serious disability.

The researcher further recommends that adverse events reporting tools for primary healthcare be adopted from the Primary Health Care Clinical Risk Management Policy (2012), which clearly lists the risks that are specific to the primary healthcare setting. The

reporting tool designed should contain elements that are informed by activities that are related to primary care. The researcher acknowledges that the tools cannot contain all the elements, but they must ensure that at least the basic elements are included so that the tools are user-friendly.

It is recommended that operational managers be included in the planning processes for resources acquisition, whether it is human, financial and material. Operational managers should be part of cash flow committees in the hospital and be allowed to prioritize activities as identified.Furthermore, the researcher recommends involving operations managers in the formulation of policies that affect day to day functioning of clinics. This will assist in developing policies on aspects like dealing with deaths in the clinics, which are currently not catered for.

The nurses are not orientated on the importance of research. It is therefore recommended that nurses should be encouraged to be involved in research activities. It is recommended that further research on this topic be conducted to further explore the issues around adverse event management.

It is recommended that the available policies be reviewed annually to incorporate new developments and recent legal cases against the Department. The available policies in the UMgungundlovu Health Districts were last reviewed in 2012.

This study was limited to uMgungundlovu Health District. It is recommended that a similar study within clinics in other districts be conducted so that a comprehensive position can be reached as to the status of adverse events in the entire province.

7. CONCLUSION

The study managed to investigate the reasons for failure to identify, report and manage adverse events. Furthermore the study managed to interrogate the available documents' ability to assist in adverse event management. The study evaluated if information management systems exist in the management of adverse event management. The study managed to investigate the work environment in the management of adverse events. The study managed to evaluate whether improvement plans exist in clinics on adverse event management.Therefore, the main objective of this study, which was to explore the reasons for not implementing available adverse events management procedures that are set down, has been achieved.

REFERENCES

BARTLETT, G., BLAIS, R., TAMBLYN, R., CLERMONT, R., & MACGIBBON, B. 2008. **Impact of patient communication problems on the risk of preventable adverse events in acutecaresettings.** Canadian Medical Association Journal. Vol. 178 N^{o} 12: 1555-1562.Canada.

CRONJE, G., DUTOIT, G., MARAIS, A., & MOTLATLA, M. 2009. I**ntroduction to Business Management.** Publishedby: Oxford UniversityPressSouthernAfrica.South Africa.

FISCHBACHER-SMITH, D., & FISCHBACHER-SMITH, M. 2009. **WeMayRememberButWhatWeDidWeLearn? DealingwithErrors, Crimes and MisdemeanorsAround Adverse Events.** Financial Accountability And Management Journal. Vol. 25 N^{o} 4: 451-474. USA.

HEIDEVELD-CHAVALKING, A., CALSBEEK, H., DAMEN, J., GOOSZEN, H. & WOLFF, A. 2014. BioMed Central Journal. Vol. 8 N^{o} 46: 1-19.UK.

JARVIS, W. 2007. **The United States approach to strategies in the battle against healthcare-associated infections, 2006: transitioning from benchmarking to zero tolerance and clinician accountability.** Journal of Hospital Infection.Vol. 65 N^{o} 2: 3-9.

KELLY, P. 2010. **Essentials of Nursing Leadership and Management.** 2nd Ed. United States: Cengage Learning. USA.

MATTOX, E. 2012. **Strategies for Improving Patient Safety: Linking Task Type to Error Type.** Critical Care Nurse Journal**.** Vol. 32 N^{o} 1: 52-60.Netherlands.

MCCULLOCH, P., KRECKLER, S., NEW, S., SHEENA, Y., HANDA, A., & CATCHPOLE, K. 2010. **Effect of a "Lean" intervention to improve safety processes and out come son a surgical emergency unit.** British Medical Journal. Vol. 341. pp. 1043-1047. UK.

MORIMOTO, T., GANDHI, T., SEGER, A., HSIEH, T., BATES, D. 2015. **Adverse drug events and medication errors: detection and classification methods.** British Medical Journal. Vol. 13. pp. 306-314. UK.

PROVONOST, P., MORLOCK, L., SEXTON, J., MILLER, M., HOLZMUELLER, C., THOMPSON, D., LUBOMSKI, L., & WU, A. 2008.**ImprovingtheValue of Patient Safety Reporting Systems.** United States Agency for Healthcare Research and Quality. pp. 1-11. USA.

RICHTER, J., MCALEARNEY, A., & PENNELL, M. 2014. **Evaluating the Effect of safety Culture on Error Reporting: A Comparison of managerial and Staff Perspectives.** American Journal of Medical Quality. pp. 1-9. USA.

Strategic Plan 2015-2019. 2015. KwaZulu-Natal Department of Health. [Online]. Available: http://www.kznhealth.gov.za/Strategic-Plan-2015-2019.pdf. [Accessed 17th April 2015]. South Africa.

Umgungundlovu Health District. 2012. Adverse Events Policy and Reporting System. South Africa.

WETZELS, R., WOLTERS, R., VANWEEL, C., & WENSING, M. 2009. **Harm caused by adverse events in primarycare: a clinical observational study.** Journal of Evaluation in Clinical practice. Vol. 15. pp. 323-327. USA.

World Health Organization. 2009. Conceptual Framework for the International Classification for Patient Safety: Final Technical Report. [Online]. Available: http://www.who.int/patientsafety/taxonomy/ICPS_Statement_of_Purpose.pdf. [Accessed 17th April 2015].Switzerland.

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