Title:
Exploring Harmful Incidents in University Hospitals in Ghana: Implications for Patient Safety

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References:
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Abstract Summary:
This study will provide insight into the nature and scale of harmful incidents, which is least studied in developing countries, and thus will contribute to improvement of patient safety and quality of care which are a great concern to patients. It will also influence patient safety policy.

Learning Activity:

LEARNING OBJECTIVES	EXPANDED CONTENT OUTLINE
The learner will be able to to estimate the incidence of harmful incidents (HIs) among patients in university hospitals.	The incidence will be determined by counting the number of HIs in patients' medical records for the previous 12 months (retrospective patient record review); and review of medical records of currently admitted patients (concurrent patient record review).
The learner will be able to assess the nature, severity, and prevention of HIs among patients in the University Hospital	The nature of HIs will be determined by identifying, among others, the type of care management the HI was mainly related to. For example, was it related to prevention or prophylaxis, diagnosis,or nursing care? The severity of the HIs will be determined by finding out whether the injury or complication caused the admission to the ward. Is the injury or complication associated with death of the patient? Is the injury or complication expected to be associated with disability/deficit at the time of discharge from the ward? Preventability of HIs will be determined by

	posing questions such as: how serious was the clinical condition of the patient prior to the occurrence of the HI? How complex was the clinical condition? What was the degree of urgency in the management of the case prior to the occurrence of the harmful incident? Was the choice of actual management of the disease appropriate? Was there a deviation in the implementation of the intended management? On reflection, would a reasonable doctor, nurse or health professional have managed the care in a similar manner?

Abstract Text:

Background: The occurrence of harmful incidents (HIs), defined as any event causing harm to the patient that was perceived to be more related to the healthcare management rather than to the patient's underlying condition, has been recognized by the World Health Organization (WHO) to be a substantial contributor to the global burden of disease. WHO has therefore called upon member states to "pay the closest possible attention to the problem of patient safety and to establish and strengthen science-based systems necessary for improving patients' safety and quality of care". Studies suggest that rates of HIs in patients in hospitals in the developed world were much higher than previously thought, with some studies showing rates of at least 8%. Of these HIs, more than 50% were judged to be preventable, and a worrying number of the patients experienced permanent disability or death as a result of the events. These reports suggest that the deaths of between 0.5% and 2% of patients in hospital are associated with an HI, which was often, but not always, preventable. It is reported that the risk of healthcare-associated infection, which is one type of HI, in some developing countries is as much as 20 times higher than in developed countries.

Majority of published studies to date, however, have been from developed countries, with little or no reports from developing or transitional economies. This knowledge gap is a serious limitation to understanding the extent of the problem at the global level and, more importantly, in specific countries. The importance of this gap must not be underestimated. Health systems in developing and transitional countries face severe health threats and challenges in a context of scarce resources and weak infrastructure. Understanding whether, how much, why, and how patients are harmed through their respective healthcare systems is essential to inform the global health policy agenda in these countries and to adopt the most effective and efficient corrective actions.

Anecdotal reports indicate that Ghanaian citizens have many concerns related to patient safety. These include patient falls, injection abscesses, surgical wound infections, hospital acquired infection/sepsis, hospital-incurred patient accident or injury, unplanned return or visit to the operating theatre during admission, unplanned open surgery following closed or laparoscopic surgery, unexpected death (i.e. not an expected outcome of the disease during hospitalisation), and any other undesirable outcomes. These HIs occur at various levels of care, whether primary, secondary or tertiary level. HIs also occur regardless of the ownership of hospital, whether government, quasi-government, faith-based or private-for-profit. However, not much studies have been undertaken to explore the nature and extent of HIs in Ghana's health care institutions.

University hospitals are quasi-government hospitals, established to provide health care to university staff and students, as well as to the general public. As a policy of all Universities in Ghana, all staff and their dependents are provided free medical care whether they are covered by health insurance or not. Students pay medical fees as part of University fees and are thus also provided free medical care when

they attend the University hospitals. Like all hospitals in Ghana, anecdotal reports from staff and students indicate that HIs do occur in university hospitals. However, the nature and extent of HIs are not clearly understood. In view of the strategic role of University hospitals in caring for large numbers of staff, students and the general public, it is critical to ensure their safety in health care. This study therefore seeks to explore the nature and extent of HIs occurring in three University hospitals in Ghana, to identify the incidence, nature, scale and preventabiity of HIs, as well as identify areas of best practices and problem areas in order to provide recommendations for safe and quality health care to staff, students and the general public.

Methods: This is an exploratory study. We will adopt five approaches proposed by the World Health Organization. These include retrospective record review of in-patients the previous 12 months, record review of current inpatients, staff interview on current inpatients, nominal group technique based on consensus method and assessment of injection safety by observation and interview.

Expected results/Significance: We expect to find harmful incidents in the operations of the University hospitals. Our findings would enable the health care providers gain an insight into the nature and causes of harmful incidents in the hospitals and thus in influence patient safety practices and policies. It will also serve as a justification for further nationwide studies, in order to address patient safety concerns of Ghana and other developing countries at large.