

Can Patients be the ‘smoke detectors’ for the NHS?

What can patients tell us about safety within three Yorkshire and Humber NHS Trusts

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Background and Aims

The National Advisory Group for the Safety of Patients in England (Berwick, 2013) recommended that “patients and their carers should be present, powerful and involved at all levels of healthcare organisations from wards to the boards of Trusts”, this is reinforced globally by the World Health Organisation (2017). Research has demonstrated that patients can identify, experience and observe safety incidents during a hospital stay (Lawton et al 2017), many of which are not identified or recorded elsewhere (O’Hara et al 2017). Using reports collected from patients we aimed to explore: (1) what concerns about safety do hospital patients report; (2) how do patients make sense of and categorise these safety concerns; and (3) what is the incidence and nature of patient safety incidents (PSIs) reported by this sample of patients (O’Hara et al 2018).

Approach and Methods

Patient safety incident reports (PIRs) were collected as part of a multi-centre, cluster, wait-list design, randomised controlled trial conducted in 33 wards across three NHS Hospital Trusts to assess the efficacy of the Patient Reporting and Action for a Safe Environment intervention (PRASE) (Lawton et al 2017).

Central to the PRASE intervention are two tools for obtaining feedback (see Figure 1):

- The Patient Measure of Safety (PMOS) – a 44 item questionnaire
- The Patient Incident Reporting Tool (PIRT) – a simple reporting proforma used in conjunction with PMOS, which allows patients to report detailed safety concerns and/or positive experiences (PIRs)

Patients were asked at their bedside (O’Hara et al 2016a):

1. Please tell us what happened with your concern or experience, in as much detail as you can.
2. Why do you feel this was a ‘safety concern’ for you?
3. What do you think could be done to stop this from happening again to you or other patients, in the future?

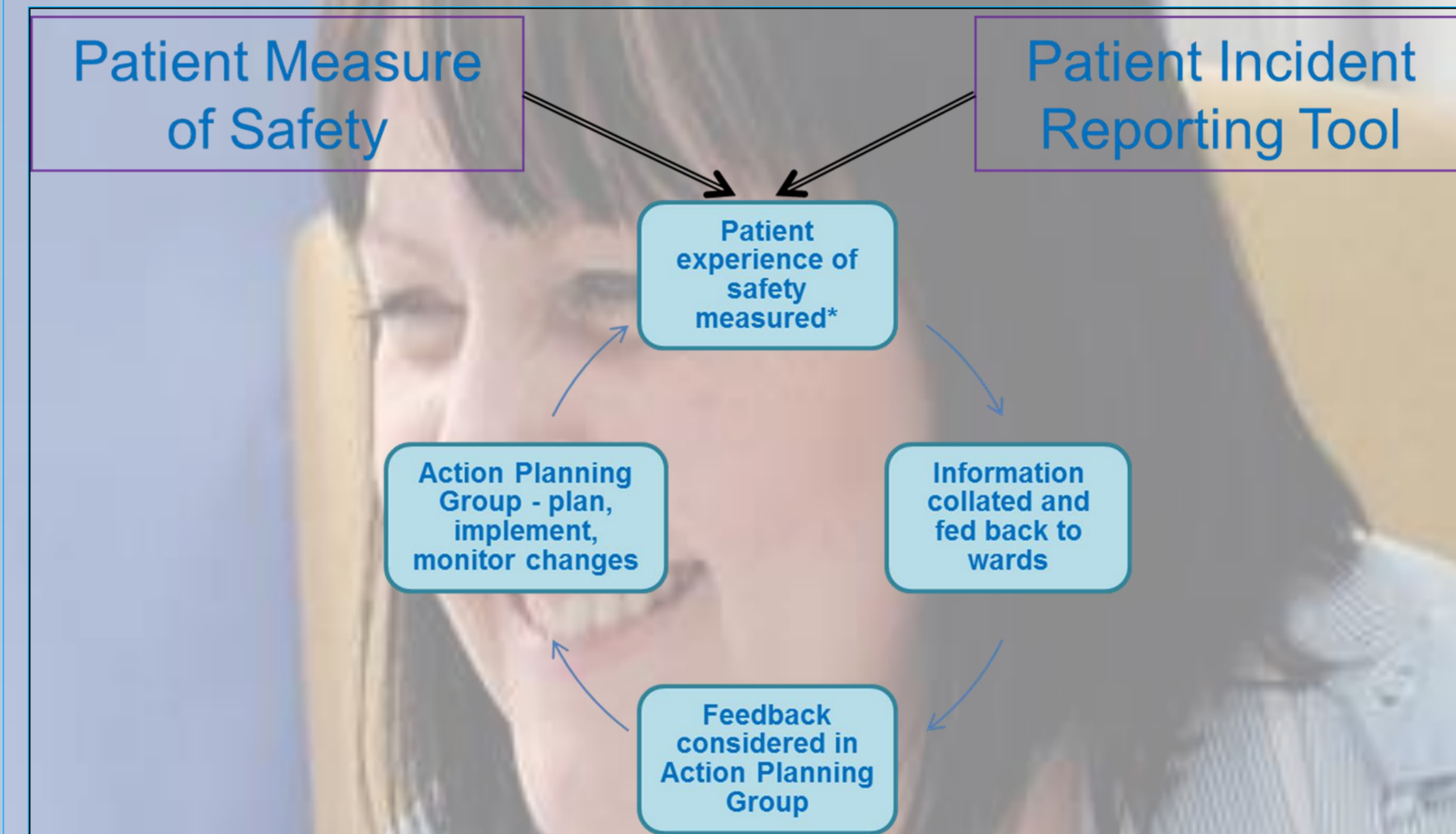
1155 PIRs were collected from 579 patients (23% of 2471 patients in the study).

A PIR categorisation system was developed by hospital volunteers who sorted the 1155 PIRs into groups and then named them as categories (O’Hara et al, 2018).

This involved 8 volunteers who attended 7 meetings which were facilitated by research staff. The volunteers produced 14 incident categories.

The PIRs were then reviewed in a two stage process by clinicians against a nationally accepted definition for a PSI: “any unintended or unexpected incident which could have or did lead to harm for one or more patients receiving NHS care.” (National Patient Safety Agency, 2011).

Figure 1:



Patient Reporting & Action for a Safe Environment

<http://www.improvementacademy.org/tools-and-resources/patient-reporting-and-action-for-a-safe-environment.html> (O’Hara et al 2016b)

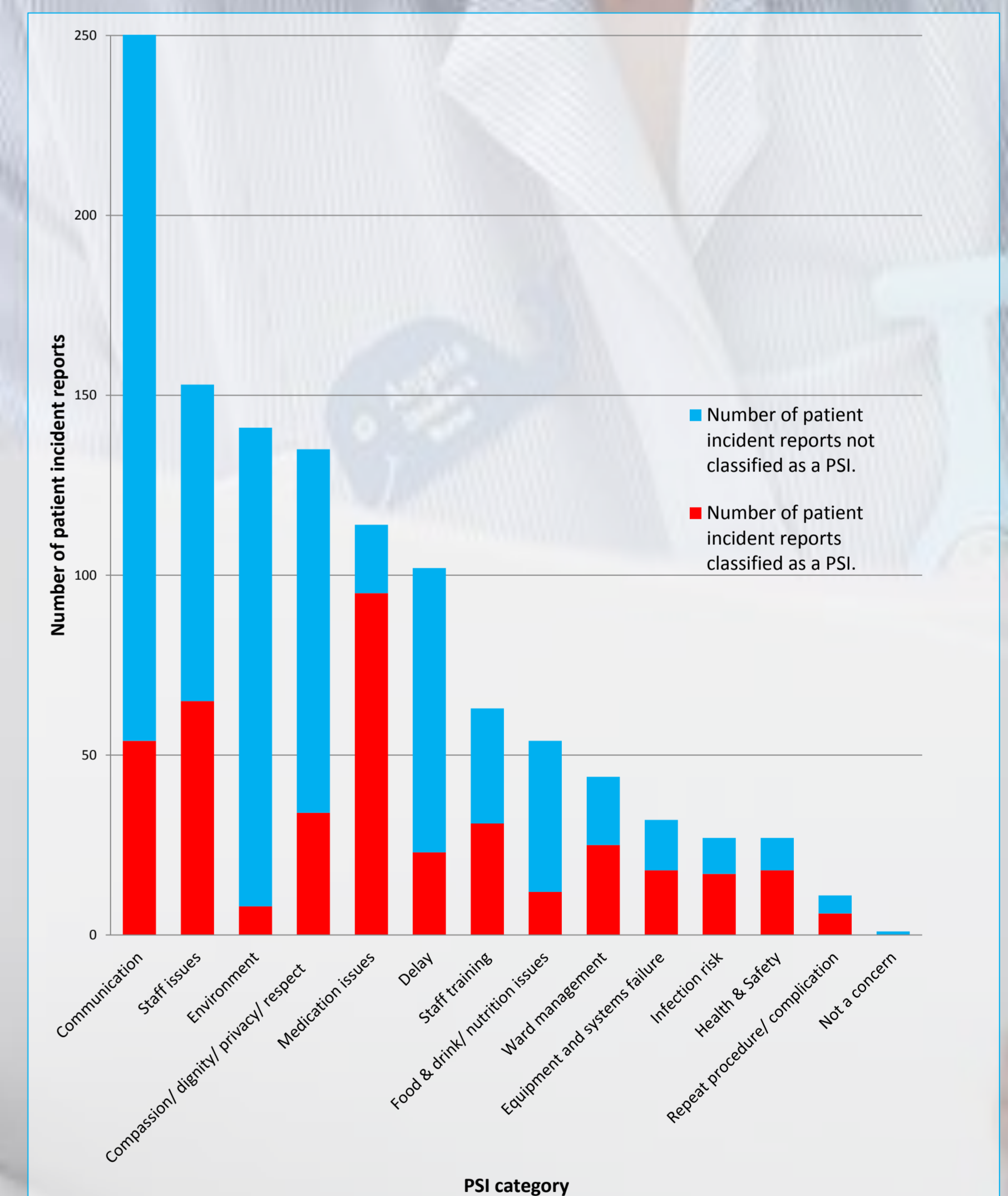
Results

Nurse/health care professional reviewers classified 603 (52% of the total PIRs) PIRs as PSIs. Medical reviewers (doctors) then classified 406 of these 603 as PSIs (35% of the total PIRs).

For some categories, e.g. medication issues, PSIs were more prevalent (83%), others e.g. communication were less prevalent (21.5%) (see Chart 1).

- 406 of the total 1155 PIRs (35%) were classified by medical reviewers as a PSI
- Of 2471 patients recruited, 264 reported one or more PSIs (10.68%)
- **1 in 10 patients identified a PSI during their inpatient stay**

Chart 1: Comparison of patient-derived safety concerns and classified PSIs



Patient incident report classified as a PSI:
Patient has epilepsy and was not woken to be given medication.

Patient incident report, not classified as a PSI: Bed pans (full) had been left in the toilets for hours and smell from one of them was horrendous.

Patient incident report classified as a PSI: Patient was almost given anti-coagulant twice in same day, but stopped nurse and told them that he had already had it.

Patient incident report classified as a PSI: There are fire doors at the end of the bay that lead directly outside. In the middle of the night an elderly confused man walked out of them with his Zimmer frame.

Patient incident report, not classified as a PSI: Patient stated that there were delays in getting anti-sickness tablets following admission. Patient needed them before meals but on several occasions got them too late.

Patient incident report, not classified as a PSI: A patient in the same bay has dementia and causes some disruption - trying to get in bed with another patient. Sometimes patient woke up and saw her standing over her and it's quite scary, especially as she was quite poorly herself.

Patient incident report classified as a PSI: On a night time, struggled getting out of bed. The call bell was put out of reach, and couldn't get out of bed and second night the call bell was again out of reach and the patient had to crawl out of bed as the side railings were put up, and when patient got out the staff were sat around eating take away.

Patient incident report, not classified as a PSI: Night staff were noisy - talking loudly, shoes - made it difficult to fall asleep. Doors slam.

Conclusion and Discussion

- **Patients can and do observe events and behaviours that can be classified as PSIs**, therefore they should be regarded as a unique source of safety information.
- We must remember that many PIRs although not classified as a PSI are still a rich source of information not collected elsewhere (for example via staff incident reports, complaints or case note review, O’Hara et al 2017). This work has identified **patient priorities that we cannot afford to ignore**. For instance, 22% (215) PIRs highlighted patient concerns regarding communication (Chart 1), only 54 of these were classified as a PSI.
- **Communication is clearly very important to patients**. Focusing on improving how we communicate with patients may have a positive impact on patient perception and experience of care.

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