The Missing Voice: Including the Patient in Adverse Event Analysis

Aim
Understand the barriers that prevent and the facilitators that promote the involvement of patients and families in Adverse Event Analysis. Determine what changes can be implemented to make it easier for patients and families to be involved in the Analysis.

Context
This project began as a scoping review for a Master of Science in Health Care Quality final project at Queen’s University.

Description of the Problem
Adverse Events occur frequently in healthcare. Although healthcare professionals speak to the importance of including patients and family in the investigation of adverse incidents, the inclusion of patients and families is rarely done.

Methods
The databases of Medline, CINAHL and PsycINFO were searched in June 2019 with limits of English language only with dates from 2010 to June 2019. The scoping review method used is the Joanna Briggs Institute for scoping reviews (1). Titles and abstracts of search findings were reviewed for assessment against inclusion criteria.

Results
The number of included studies were five. All were qualitative studies. Seventeen barriers and seven facilitators were identified in the five studies. They were categorized using a human factors framework (2).

Barriers
- Why is it so challenging to involve patients and families in Adverse Event Analysis?
  - People factors
    - Patients and families may not want to be involved (3,4)
    - HCW ability to prioritize dealing with Adverse Events (3,6)
    - Conflicting perspectives of HCW and patient and family (3,4,6)
    - Complex issues that are difficult to resolve (3,5,6)
  - Task factors
    - Definitions of Adverse Event is not always clear (3,4)
    - No standards for how to involve patient and families (3,4,6)
    - Limited time frames to do reviews (3,4)
    - Legal concerns (3,4)
  - Organizational Factors
    - Limited time frames to do reviews (3,4)
  - External Factors
    - Dominant medical perspective does not value patient and family experience (3,4)
    - Protect the professionals involved (3,4)

Facilitators
- What would make it easier to involve patients and families in Adverse Event Analysis?
  - People factors
    - Belief that patients and families should be involved in incident analysis (3,4)
    - Clearly define the role of patients and family members (6)
    - Defining the roles of the stakeholders (6)
  - Task factors
    - Ongoing communication and support for patients, families and HCW (3,6)
    - Strong organisational leadership (6)
  - Organizational Factors
    - Ongoing communication and support for patients, families and HCW (3,6)
    - Strong organisational leadership (6)
  - External Factors
    - Knowledge of how to protect proceedings legally before involving patients and families (3,4)

Benefits
- Reasons why participants thought that patients and families should be involved in Adverse Event Analysis.

References

Next Steps
- What can we do to make patient inclusion in Adverse Event Analysis possible?
  - Must have organizational support and resources dedicated to involving patients and families
  - Create policies, standard work and guidelines for involving patients and families
  - Timelines need to be creatively managed for patient and family participation
  - Voice of patients and families must be included in advancing this work
  - Share the work you are doing so we all can learn

Implementation
This work has helped in understanding what the barriers and facilitators to involving patients in event analysis after an adverse event are. We have begun by drafting standard work and interviewing patients involved in serious adverse events.