The Missing Voice:

Including the Patient in Adverse Event Analysis

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The Patient's Journey

Home → Doctor's Office → Ambulance → Urgent care center → Hospital room → **Adverse Event** → Operating Room → Recovery Room → Postpartum Unit → Home

Research

Queen's University

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 Methodology 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].

Results

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 [3,6]
Task factors	• HCW ability to prioritize dealing with Adverse Events [3] • Conflicting perspectives of HCW and patient and families[3] • Difficult conversations to have [3,4,6] • No standards for how to involve patient and families [3,4,6] • Complex issues that are difficult to resolve [3,5,6]
Organizational Factors	• Definitions of Adverse Event is not always clear [3] • Limited time frames to do reviews [3,6] • Legal concerns [3,4]
External Factors	• Dominant medical perspective does not value patient and family experience [7] • 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 [3-7]
Task factors	• Clearly define the role of patients and family members [4] • Defining the roles of the stakeholders [4]
Organizational Factors	• Ongoing communication and support for patients, families and HCW's [4] • Strong organizational leadership [4]
External Factors	• Knowledge of how to protect proceedings legally before involving patients and families [4]

Benefits

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

- To support patients and families in dealing with event [3]
- Information given by patients and families can prevent similar events [4]
- Patient lack of familiarity with hospital processes can give a fresh perspective [4]
- Patients offer a unique perspective on norms and quality of care [4]
- Provide patients and families information and answers to questions [6]
- Display empathy and regain trust of patients [6]
- To prevent legal proceedings or escalation of situation [3]
- Healthcare leaders can verify operational details and explore deeper [6]

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.

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References

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