

What is the problem?: Patient harm is a leading cause of global disease burden with considerable morbidity, mortality and economic impacts for individuals, their families and wider society. A large body of evidence exists for strategies to improve safety and reduce harm. However, it is not currently clear which patient safety issues are being addressed globally, and which factors are the most (or least) important contributors to improvements in patient safety.

Therefore, we aimed to survey international patient safety experts to: (1) identify the nature and range of patient safety issues being addressed globally, and (2) explore their perspectives on aspects of patient safety governance and systems that are perceived to provide value or are not effective in improving outcomes for patients.

Methods: English-speaking Fellows and Experts of the International Society for Quality in Healthcare (ISQua) were invited to participate in a web-based survey and in-depth semi-structured interview discussing their experience in implementing interventions to improve patient safety. Data collection focused on understanding the elements of patient safety governance that influence outcomes. Demographic survey data were analysed descriptively. Qualitative data were coded, analysed thematically using an inductive approach, and mapped deductively to the System-Theoretic Accident Model and Processes (STAMP) framework. Findings are presented as themes and a patient safety governance model. The study was approved by the University of South Australia Human Research Ethics Committee (203467).

Results:

Twenty-seven experts (59% female) participated. Most hailed from Africa (n=6, 22%), and Australasia or the Middle East (n=5, 19% each). The majority were employed in hospital settings (n=23, 85%), and reported blended experience across healthcare improvement (89%), accreditation (76%), organisational operations (64%) and policy (60%).

Thematically, 532 textual segments were grouped into 90 codes (n=44 barriers, n=46 facilitators) and used to identify and arrange key patient safety governance actors and factors as a “system” within the STAMP framework (Figure 1). Four themes and 12 sub-themes for improved patient safety governance were identified – see Box 1 for themes and indicative quotes from participants.

Box 1: Themes, subthemes and quotes (with % of textual segments relevant to the theme)

Theme 1: Organisational culture, safety and quality mindsets (77%)

- Organisational culture and leadership priorities**

“Leaders set an example by making patient safety the highest priority”
- Staff engagement**

“it’s gotta be bottom up. I think memos from health departments don’t help.”
- Endorsement of quality**

“To cultivate positive attitudes and behaviours relating to patient safety, organisations should focus on promoting common values.”

Theme 2: Policies and processes to investigate, implement and demonstrate impact (68%)

- Policy**

“I think there’s a definite correlation with culture and that comes from policies and national policies.”
- Regulatory bodies**

“...our local regulatory ... they have a standard for patient safety that is really minimal...really minimal. So, it hasn’t put any demand on the facility to actually drive their agenda.”
- Processes – data informing and informed by practice**

“But if all they see, and all they work with is what’s reported in incident report forms, which is pressure ulcers, medications and falls, then that’s where their energy goes...Rather than looking more broadly and saying those questions: what procedures are we doing here where the evidence is that it’s low value, you know? That perhaps, you know, from morbidity mortality we shouldn’t have operated, how are we supporting people to make the right decisions about the care we provide and the quality of that care? And whether it’s appropriate?”
- Implementation, interpretation and demonstrating impact**

“Sometimes the standards may be given out at the national level, but they’re just not translated on the ground. They just remain as things in the document, but there’s no follow up to really make sure that they’re implemented at the facility level.”

Theme 3: Staff support, upskilling and shared learning (68%)

- Staff support and capacity**

“I think if they [staff] feel supported and comfortable that you know, nothing adverse will come, it’s just about learning, I think they’re more than happy to support that process.”
- Staff upskilling**

“there’s an awful lot that needs to go into teamwork and the non-technical skills, the communication skills for everybody.”
- Shared learning**

“International collaborations have been valuable – learning what has been successful in other countries

Theme 4: Patient engagement, experience, and expectations (22%)

- Patient engagement and experience**

“Emerging Leaders in Patient Safety, we had on the, we had 30 scholars, 10 faculty, 2 or 3 of the faculty were always patient advocates. And the feedback from the scholars saying: this is the best part; I’d never dreamt of the patient’s experience before. And several of those people totally changed their careers and gone into patient safety as a result of the, you know.....so, you know, I think the patient experience is something people need to hear.”
- Patient expectations**

“Patient attitudes and health literacy beginning to show signs of change but will take a long time to alter entrenched culture of healthcare.”

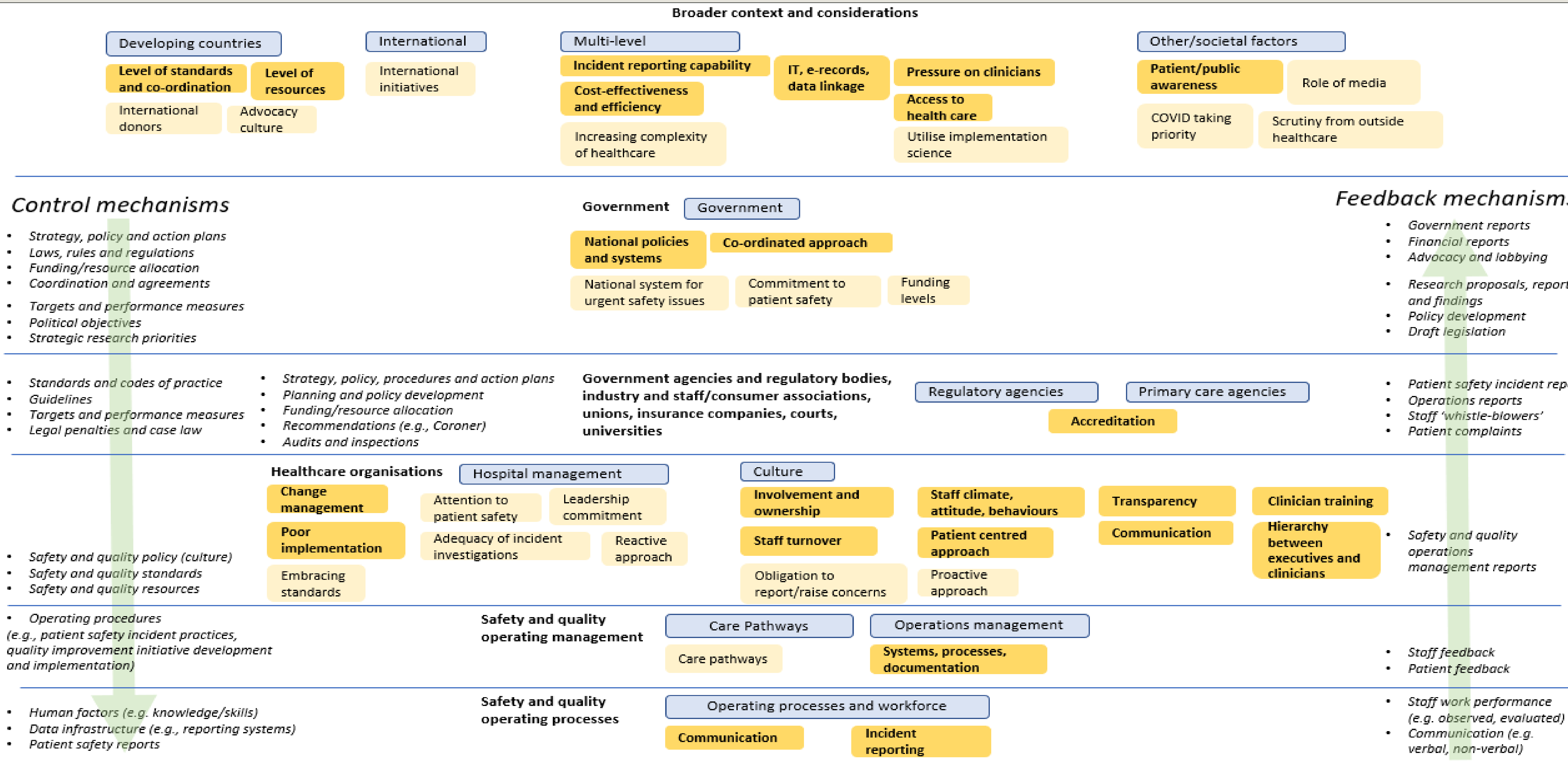


Figure 1. Adapted STAMP systems model for patient safety governance

Control and Feedback mechanisms in italics. Key factors related to patient safety governance and systems are noted in yellow boxes with deeper coloured yellow boxes and bolded text showing factors with ten or more responses from participants. These are organised into different STAMP hierarchical levels in plain bold text and sub-levels in blue boxes. Factors were aggregated including across barriers and facilitators and renamed into neutral factors (for example, lack of access to healthcare [a barrier] and access to healthcare [a facilitator] were aggregated and renamed access to healthcare). Factors mentioned by less than 3 participants were excluded.

References:

Hibbert PD, Stewart S, Wiles LW, Braithwaite J, Runciman WB, Thomas MJW. Improving patient safety governance and systems through learning from successes and failures: Qualitative surveys and interviews with international experts. Submitted to the International Journal for Quality in Health Care, 2023.