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Exploring Patient and Family Experiences of Incident Reviews after a Patient Safety Incident

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INTRODUCTION

- It is estimated the prevalence of adverse events in the Irish healthcare system to be 14% (Connolly et al., 2021).
- Investigative processes after a patient safety incident can compound the harm experienced by patients and their families (Wailling et al., 2022).
- When healthcare organisations neglect the human factors of a patient safety incident, it can contribute to the harm patients experience, as they often desire to feel heard and validated.
- Including patient perspective has been identified as a way of improving patient safety investigations. Patients and families have been identified as being a form of resilience in supporting the quality and safety of healthcare services (O'Hara et al., 2018).
- Exploring patient's experiences of patient safety incidents may help to prevent the recurrence of these incidents and help to improve healthcare organisations handling of these events.

AIM

The research on patient safety in Ireland is growing, however, the research on patient and family perspectives of the aftermath of patient safety incidents is limited. This study explores the perspectives and experiences of patients and family members during patient safety incident reviews in Ireland.

Hypotheses:

1) To understand patient/families experience of taking part in an incident review.

2) To explore the challenges patients/families experience during the incident review process.

METHOD

Participants

Participants (N = 6, Male = 3, Female = 3) were recruited through patient safety organisations and patient support organisations. Inclusion criteria: participants must have experienced a patient safety incident and taken part in the review process/be a family member of a patient, be over 18 and reside in Ireland.

Procedure

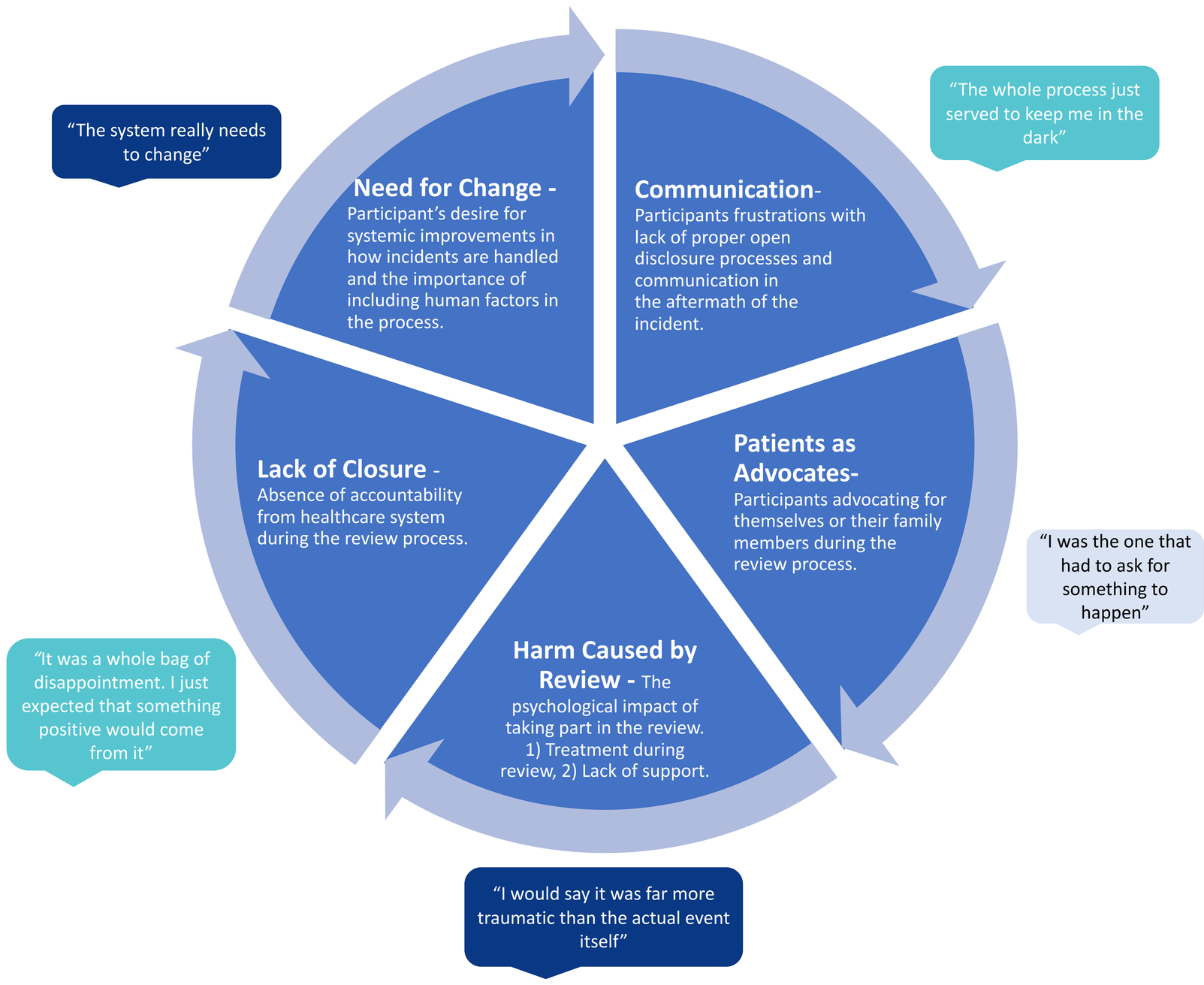
Participation in the study was voluntary, and informed consent was obtained from each participant. Semi-structured interviews lasting 45-60 minutes were conducted.

Data Analysis

Interview transcripts were analysed using a thematic analysis approach, using Braun and Clarke's (2006) six phase guide.

RESULTS

- Five themes emerged from the thematic analysis - Communication, Patients as Advocates, Harm caused by review process, Lack of closure and Need for change.
- The themes derived from the interviews highlight participant's perspectives of the various challenges they encountered during the incident review. Participant's insights depicted in the five themes that emerged from thematic analysis demonstrate the complexity of incident reviews.



CONCLUSIONS & RECOMENDATIONS

- Consistent with other patient and family studies, participants perceive the review process to be harmful, having negative impacts on their mental health during an already challenging time.
- Patient and family experiences of how reviews are carried out are instrumental in determining the success of incident reviews.
- Findings suggest that from the patient/family perspective, an effective incident review involves an open dialogue between patients and the healthcare organisation, timely and person-centred communication, supporting patients and family throughout the process, closure from receiving an apology and accountability and ensuring learnings are extracted from the review to make the system safer.
- Future research should examine what patient and family involvement should look like in incident reviews from the perspective of multiple stakeholders including patients, their families and healthcare professionals.

Limitations

- This sample represents a small number of the total patient safety incidents that occur each year in Ireland and is not representative of all patient safety incidents.
- Recruiting this small sample size was a challenge to the research team.
- This may highlight patient's and family's reluctance to revisit traumatic incidents.

REFERENCES

Braun, V., & Clarke, V. (2006). Using thematic analysis in psychology. *Qualitative research in psychology*, *3*(2), 77-101.

Connolly, W., Rafter, N., Conroy, R. M., Stuart, C., Hickey, A., & Williams, D. J. (2021). The Irish National Adverse Event Study-2 (INAES-2): Longitudinal trends in adverse event rates in the Irish healthcare system. *BMJ Quality & Safety*, *30*(7), 547–558. https://doi.org/10.1136/bmjqs-2020-011122

O'Hara, J., Reynolds, C., Moore, S., Armitage, G., Sheard, L., Marsh, C., Watt, I., & Wright, J. (2018). What can patients tell us about the quality and safety of hospital care? Findings from a UK multicentre survey study. *BMJ Quality & Safety*.

Wailling, J., Kooijman, A., Hughes, J., & O'Hara, J. K. (2022). Humanizing harm: Using a restorative approach to heal and learn from adverse events. *Health Expectations*, *25*(4), 1192–1199. https://doi.org/10.1111/hex.13478

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