Editorial

Role of electronic patient reported safety incidents in improving patient safety and care

The simplest definition of Patient Safety defined by World Health Organization (WHO) is ‘the prevention of errors and adverse effects to patients associated with health care’ [1]. According to WHO, the magnitude of patient harm while receiving healthcare is 1 in 10 patients globally, incidence of patient safety incidences is approx. 43 million per annum, and medication error cost is approx. 42 million USD annually [2]. National Health Service (NHS) defined Patient Safety Incidents (PSIs) as ‘any unintended or unexpected incident which could have, or did, lead to harm for one or more patients receiving healthcare’ [3]. Understanding and addressing the PSIs are not only important from the patient safety perspective but they also have a key role in the patient centered healthcare paradigm. Most of the current safety incident reporting tools rely on the information provided by healthcare professionals and administrators, but the evidence suggests that patient generated reports can provide a valuable source of information, which is not identified by traditional healthcare monitoring systems [4]. Therefore, in order to overcome the PSI issues and promote safe healthcare, the feedback from patients’ side using Patient Incident Reporting Tools (PIRTs) is a sine qua non. Since patients are the direct receivers and witness of the whole care process, the knowledge of safety incidents gained from patients’ experiences and their family members’ observations can identify unsafe practices and adverse events, provide broad interpretation of events than healthcare providers, and produce reliable reports for learning and improvements [5].

The related literature has shown that the recording of patients’ reports in electronic healthcare providers’ systems is generally uncommon and has its own challenges, as most of the previous studies have gathered the PSI data from patients through interviews and surveys [5]. The utilization of electronic PIRTs for analyzing the patient reported safety incidents in the existing setups of healthcare organizations is relatively a new field and is evolving with the time. The incorporation of PIRTs in the existing electronic healthcare reporting systems can serve and assist healthcare organizations in overcoming the safety lapses and issues encountered during the care processes and prevent them from happening again. Sahlstrom et al. [5] presented an interesting study to analyze and use the patient reported PSIs in Finnish healthcare organizations by incorporating a patient reporting tool in a widely used healthcare system at national level. Based on the outcomes of this study, we derive the following insights in this field. First, patients reported PSIs alone, without the involvement of healthcare providers and strategies of healthcare organizations, are not sufficient for addressing patient safety issues. Second, the support and willingness of healthcare professionals for understanding and incorporating the knowledge gained from these patients’ reported exercises into their routine practices is required. Third, the healthcare organizations need to learn from the available information received from patients’ reported feedback and should take the effective measures to address the identified safety issues. Fourth, the senior management of the healthcare organizations needs to establish strong patient safety environments within their organizational setups. Fifth, the appropriate utilization of the outcomes from these patient reported exercises can facilitate in building clear strategies and policies at the national level for patient safety and care. However, we must not forget the challenges associated with the implementation of PIRTs, e.g. additional finance, technical issues, data collection, knowledge transformation and the adoption barriers, that must be considered and planned well [5, 6].

The concept of informed patient already exists on the roadmap of future healthcare [7], so for the way forward, we believe that the healthcare organizations and policy makers should involve patients as an integral constituent in reshaping the healthcare delivery process and improving healthcare quality management—in general; and should provide the opportunities to the patients for reporting their unique safety experiences through the electronic reporting tools, in specific. Moreover, in order to achieve the tangible benefits from the patient reported safety incidents and tools, the data must be analyzed, evaluated, interpreted and utilized appropriately for risk assessment, organizational learning and policy making for patient safety and care.

References


MOHY UDDIN, and SHABBIR SYED-ABDUL

1 King Abdullah International Medical Research Center, Executive Office, King Saud bin Abdulaziz University for Health Sciences, King Abdulaziz Medical City, Ministry of National Guard Health Affairs, Riyadh 11426, Kingdom of Saudi Arabia, and

2 Graduate Institute of Bioinformatics, Taipei Medical University, Taipei 10675, Taiwan

Address reprint requests to: Shabbir Syed Abdul, Associate Professor, Graduate Institute of Biomedical Informatics, Taipei Medical University, 15F., No. 172-1, Sec. 2, Keelung Rd., Da’an Dist., Taipei, Taiwan. Tel: +886 2-6638-2736 Extn.1514; Fax: +886 2-6638-0233; E-mail: drshabbir@tmu.edu.tw