Patient-reported experiences of patient safety incidents need to be utilized more systematically in promoting care

Worldwide, many patients experience patient safety incidents (PSIs) during their care. PSIs are any unintended or unexpected incidents which could potentially cause or have already caused harm to patients. We studied patient-reported PSIs and how the reports concerning them had been used to promote safe care in healthcare organizations in Finland. We analyzed 656 voluntary PSI reports from the period 2009–2015. The figure below presents what we studied.

We found that patients had reported multiple types of incidents, focusing mostly on problems with information flow (e.g., not received enough information about one’s care, incorrect patient information) and problems with medication (e.g., wrong drug given, not receiving a drug at all, unexpected reaction to drug). Most of the incidents did not cause any harm to patients. Many of the patients’ reports included their suggestions on how such incidents could be prevented from happening again. Most of the suggestions were practical and often focused on processes (e.g., identifying risks, using checklists and identification wristbands, informing patients in a clear and understandable way, improving health care professionals’ mutual support and consultation). Patients also suggested that incidents could be prevented by better listening to them, their family members, and parents, and by improving the safety of the healthcare environment (e.g., keeping rooms clear of clutter, regularly checking the safety of beds). Despite the high number of suggestions from patients, only few had led to practical changes in the healthcare organizations. Our findings revealed that patients can report multiple types of PSIs and are able to suggest very useful measures to prevent future PSIs. However, patients’ PSI reports are not utilized enough in promoting safe care in healthcare organizations.

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Objective: To analyze patient safety incidents (PSIs) reported by patients and their use in Finnish healthcare organizations.

Study Design: Cross-sectional study.
Setting: About 15 Finnish healthcare organizations ranging from specialized hospital care to home care, outpatient and inpatient clinics, and geographically diverse areas of Finland.
Participants: The study population included all Finnish patients who had voluntarily reported PSI via web-based system in 2009–15.

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Main Outcome Measure(s): Quantitative analysis of patients’ safety reports, inductive content analysis of patients’ suggestions to prevent the reoccurrence incidents and how those suggestions were used in healthcare organizations.

Results: Patients reported 656 PSIs, most of which were classified by the healthcare organizations’ analysts as problems associated with information flow (32.6%) and medications (18%). Most of the incidents (65%) did not cause any harm to patients. About 76% of the reports suggested ways to prevent reoccurrence of PSIs, most of which were feasible, system-based amendments of processes for reviewing or administering treatment, anticipating risks or improving diligence in patient care. However, only 6% had led to practical implementation of corrective actions in the healthcare organizations.

Conclusions: The results indicate that patients report diverse PSIs and suggest practical systems-based solutions to prevent their reoccurrence. However, patients’ reports rarely lead to corrective actions documented in the registering system, indicating that there is substantial scope to improve utilization of patients’ reports. There is also a need for strong patient safety management, including willingness and commitment of HCPs and leaders to learn from safety incidents.
Layman’s summary