A collaborative approach to improving patient safety: Patient & healthcare professional perspectives

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Background: There is an international emphasis on patient involvement in improving patient safety. Current campaigns aim to promote patients' proactive contributions to their own safety. However, concerns have been raised about the acceptability to patients of some approaches and their possible unintended consequences, such as damage to the patient-provider relationship. This may be due to a lack of consultation with service-users (patients & their relatives) & frontline healthcare professionals (HCPs) in the development process.

Study aim: To understand from the perspectives of service-users & healthcare professionals: how they feel about patients having a role in improving their safety; what users could do to enhance patient safety; how such a role could be best supported & how service-users & healthcare professionals could work together, collaboratively, to achieve this.

What we did ...

Qualitative study with 20 service users & 38 frontline HCPs (doctors, nurses, nursing auxiliaries, ward pharmacists). Two hospitals in North East England, UK.

What they told us...

Perceived benefits

"Welcome the opportunity to ask Q's & know more about our care"

"Better understanding of what is happening & what to expect"

"When patients ask questions it shows they are interested in their care"

"Improved compliance & satisfaction through better understanding"

Perceived negative consequences

- Fear upsetting HCPs by appearing "rude", "cheeky" or critical
- Fear being rebuffed & being labelled a "difficult patient"
- Will appear ignorant, uninformed
- Care will be compromised

Beliefs about capabilities

- Lack of awareness & expertise
- Deference, "lay person"
- Vulnerability when a patient
- Lack of interaction opportunities
- Uncertainty about who to ask

What patients & relatives can do

Enhance medication safety by:
- Asking about medications & why they take them
- Keeping an up to date list of medicines
- Confirming the accuracy of medications at admission
- Asking about unfamiliar meds administered at drug round
- Learning about & reporting side effects of medicines
- Confirming the accuracy of medicines given at discharge

Enhance hygiene safety by:
- Adhering to recommended hygiene protocols
- Reminding HCPs to wash their hands

Enhance other aspects of safety by:
- Avoiding falls by being aware of hazards on the ward
- Avoiding falls by knowing patient's own limitations
- Reporting suspected deterioration or change in patient
- Checking & marking the correct surgical site
- Asking about what to expect following discharge
- Relative acting as patient's advocate

Perceived negative consequences

- Patients will lose trust in HCPs
- Damage patient confidence in care
- Additional time needed
- Extra work burden

Beliefs about roles

- Concerns about "losing face", appearing unprofessional
- Patients don't want to know

"HCPs need to SAY its 'OK to ask'"

"Hospital is *THEIR* domain"

"Don't want to *TROUBLE* busy staff"

HCPs are KEY

"HCPs need to foster involvement"

"HCPs empathise with patients' fears & concerns'"

"Recognise the need to "permit" involvement"

Lessons learnt: Both service-users & HCPs provided invaluable insights into how patients could play a role in improving their safety but they struggled to think imaginatively outside of their current experience. Other supplementary methods were necessary.

Key message: Supporting patient involvement in their own safety requires a collaborative approach between service-users & HCPs. It is clear from this study that a service-user role requires active support and permission from the HCPs providing their care. Overcoming this major barrier is the basis on which the patient role can develop beyond that currently in place.

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