

Patient safety incidents involving acutely sick adults in hospital assessment units in England and Wales: a mixed methods analysis

Authors: Alexandra Urquhart,^A Andrew Carson-Stevens,^A Sarah Yardley^B and Elin Thomas^A

Introduction

Around 6% of medical encounters result in preventable patient safety incidents, and 12% of these result in severe or fatal outcomes.¹ The acute medical unit (AMU) was introduced in 2004 to improve patient outcomes by allowing patients referred from general practice to receive specialist medical care faster.² However, healthcare poses risks to all patients, and it is well documented that acutely sick patients are at heightened risk of unsafe care due to medication errors, treatment delays and complications arising from multiple care handovers.^{3–6}

Patient safety is predicated on understanding why errors occur and using this to redesign care to mitigate or remove risks to future patients. Incident reporting systems offer a means to learn from patient safety incidents and improve future practice. We report the first national analysis of patient safety incidents occurring in AMUs across England and Wales. This study identifies the most frequently reported incidents resulting in severe harm or death, analysing characteristics and underlying causes of harm in AMUs reported between 2005 and 2015.

Methods

A retrospective cross-sectional mixed-methods approach was used. Incidents reported between 2005 and 2015 describing severe harm and death in the AMU were identified in the National Reporting and Learning System (NRLS) using the location category 'Accident & Emergency/Minor Injury Unit/Medical Assessment Unit'. Reports from outside the AMU were excluded, such as emergency department reports. An *a priori* classification process, using an established multi-axial coding framework aligned to the World Health Organization's International Classification for Patient Safety was applied to describe incident type, contributory factors, outcome and harm level. Thematic interpretative analysis was then undertaken to gain further learning from reports, notably considering how reporters described underlying causes of incidents. Following literature searches for pre-existing interventions, findings were synthesised to understand priority areas to reduce healthcare-associated harm in the AMU and

identify whether these might be amenable to existing evidence-based interventions.

Results

Three-hundred and seventy-seven AMU reports describing incidents resulting in severe harm or death were identified. The most common incident types were diagnostic errors (n=79), medication-related errors (n=61) and failures monitoring patients (n=57). Incidents commonly stemmed from a lack of active decision making in patient care and communication failures between teams, including failure to respond to early warning scores. Multiple handovers and transfers of care put patients at heightened risk of unsafe care. Meta-themes generated from qualitative analysis included implicit reliance on patient self-advocacy in the acute environment; a lack of care coordination during patients' admissions; and care decisions being made on incomplete patient information, leading to potentially inappropriate decisions being made. Evidence-based interventions that could be used to target these priority areas include electronic prescribing and monitoring systems; using forcing checklists to reduce diagnostic errors; and handover systems allowing the transfer of live patient information.^{7,8}

Conclusion

The findings from this study highlight priority areas to target to improve patient safety in AMUs. System-focused evidence-based solutions exist to improve safety in the AMU but cannot fully address the risks when patients are unable to self-advocate and new initiatives are required to address this. ■

Conflicts of interest

None declared.

References

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Authors: ^ACardiff University, Cardiff, UK; ^BCentral and North West London NHS Foundation Trust, London, UK

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