Carers' contributions to the prevention of medical errors in hospitals
Summary of PhD research findings

Researchers:

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MAIN FINDINGS

Background: Healthcare policies in Australia, and globally, increasingly encourage health professionals to work with carers during hospitalisation to prevent mistakes in the patient's treatment. Preventing mistakes in healthcare is also known as ensuring 'patient safety'. Very little research had previously investigated how carers experienced contributing to patient safety, particularly from the carers' perspective.

Aims of this research:
The aims of this research were to understand:

1. Why carers became involved in preventing medical mistakes during the hospitalisation
2. The types of actions carers took to prevent medical mistakes
3. The consequences for carers of intervening to prevent mistakes.

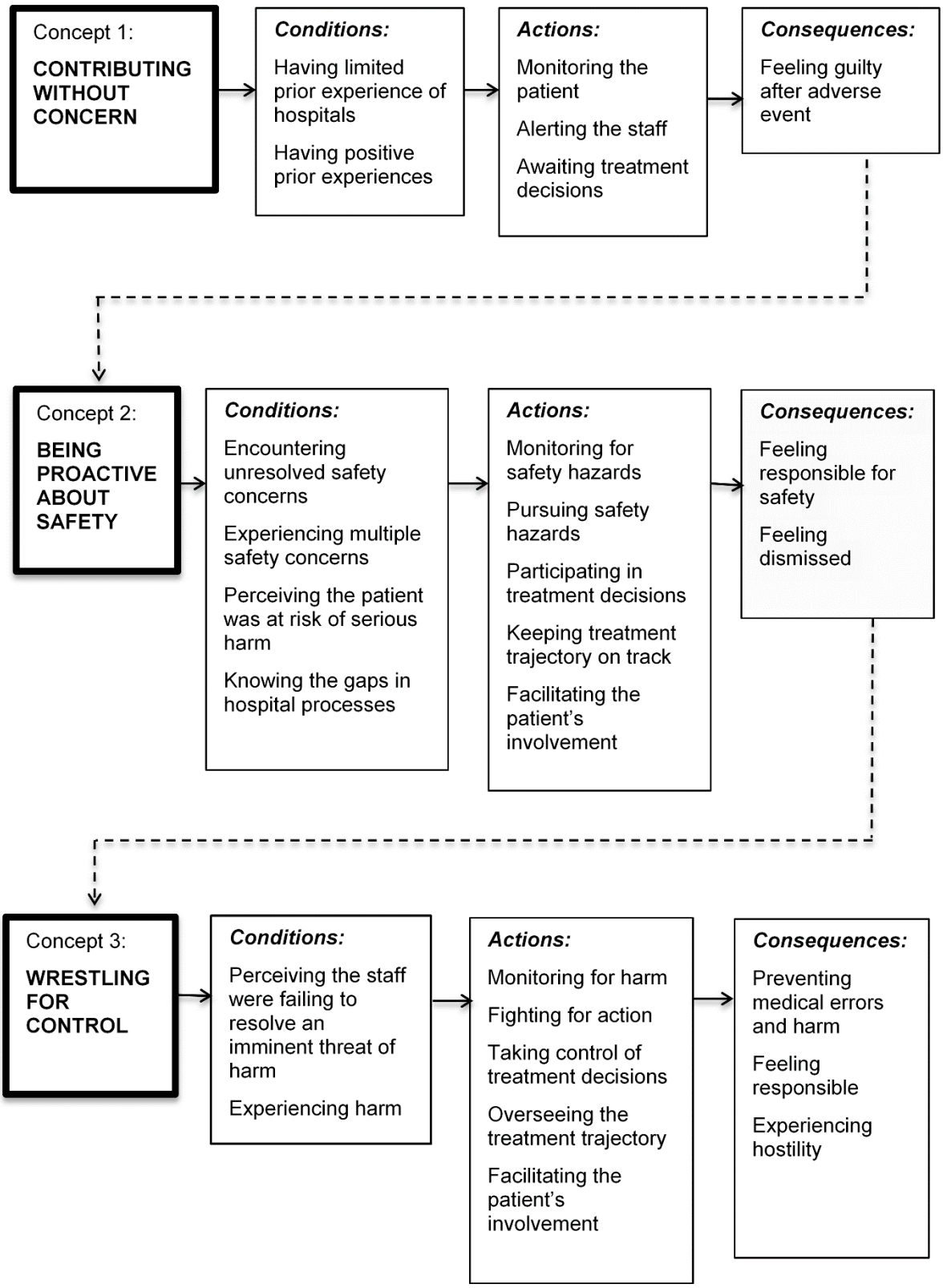
Method: I used a research method called 'constructivist grounded theory' to do this research. This method involved the following steps:

1. I Interviewed 32 carers ('participants') who had supported a family member or friend in hospital, and had concerns about the patient's treatment or care. During the interview, I asked participants to tell me about their experience, in particular their role in helping to prevent mistakes.
2. I recorded and transcribed each interview word-for-word, and asked each participant if they wanted to check the transcript before it was analysed.
3. I interpreted each transcript for key themes or ideas, as well as similarities and differences between participants and their experiences.
4. From this analysis, I developed a possible explanation (or theory) about the reasons carers acted in particular ways to prevent medical errors, and also the consequences for carers of doing so.

Results: I found that carers played a significant and unique role in preventing mistakes in the patient's care in hospital, engaging in the process of what I termed 'patient-safety caring'. The process, shown in Figure 1 below, involved the following three intensities of patient-safety caring: 'caring without concern' (low intensity), 'being proactive about safety' (moderate intensity) and 'wrestling for control' (high intensity). Some carers engaged at one level of intensity only whereas other carers increased their intensity over the course of a hospitalisation.

Figure 1: The process of patient-safety caring

Reference: Merner et al (2019) "I'm Trying to Stop Things Before They Happen": Carers' Contributions to Patient Safety in Hospitals. *Qualitative Health Research*. 10.1177/1049732319841021



Carers who engaged in 'caring without concern' had a high level of trust in hospital staff. They were usually carers who either had limited or positive prior experiences of hospitalisation. Carers who contributed without concern were more focused on other aspects of the patient's care (such as providing emotional or physical support), than the possibility of mistakes occurring. Carers at the low intensity level helped to prevent mistakes by:

- monitoring for any noticeable deterioration in the patient's condition; and
- alerting staff to safety risks (e.g. the possibility of an infection risk from inadequate cleaning of the hospital environment).

Carers who contributed without concern were less likely than carers at higher intensity levels to question the staff's planning and delivery of treatment to the patient.

Carers who participated in 'being proactive about safety' were those who had substantial previous experience of the hospital system, or were concerned that a safety risk in the patient's care was not being addressed by the staff (for example, a carer spoke about their frustration that the patient was repeatedly being given the wrong medication despite asking the staff to fix the error). Carers at this level still trusted staff, but felt they needed to become more proactive in their own actions to make sure the patient's care went smoothly. This meant carers contributed to preventing mistakes by:

- Becoming actively involved in discussions about the patient's treatment (including questioning staff when they were unsure whether a particular treatment plan was appropriate)
- Helping to make sure the patient's treatment stayed "on track" (e.g. by filling in the nurses at each handover shift about important aspects of the patient's care); and
- Assisting the patient to speak up for themselves (when the patient was able to) about their care and treatment options.

Carers who participated in 'being proactive for safety' could experience negative consequences. These included feeling dismissed by the staff when they raised concerns, and feeling responsible for stopping things going wrong in the patient's care.

Carers who engaged in the highest intensity of patient-safety caring were those who were 'wrestling for control'. These carers often had very low (or no) trust in the staff to keep the patient safe from medical errors. Generally, these carers had witnessed the patient actually experiencing a medical error, or were very concerned that one may occur. This meant carers at this intensity level became very proactive, and sometimes aggressive, in advocating for the patient. Carers at this level would:

- Watch over the patient as much as possible to ensure mistakes were not made in their care
- Take control of treatment decisions (e.g. if a carer disagreed with the staff's treatment of a patient, they may organise for the patient to be discharged or for a particular treatment to be stopped)
- Fight for action when they felt obvious threats to the patient's well-being were not being addressed (e.g. they would ask for a second opinion, make a complaint, go to an external body to resolve their concerns).

Carers who engaged in high intensity patient-safety caring believed they achieved a good outcome for the patient by preventing significant medical errors. However, this outcome often came at significant expense for the carer themselves and their relationship with hospital staff. For example,

many carers at this level experienced hostility from staff when they became assertive, and also felt a high degree of personal responsibility for keeping the patient safe from harm in hospital.

Reflections on the results: This research proposes that carers can provide continuous, wide-ranging protection from medical errors at varying levels of intensity. Carers' safety contributions were underpinned by their unique knowledge of the patient and time spent at the patient's bedside. Innovations in safety and quality policies and practice are needed to improve staff recognition and acceptance of carers' contributions to medical error prevention. More focus is required at a government and hospital level on approaches that aim to avoid shifting an unreasonable degree of responsibility for safety to carers.

I conclude that further efforts are needed to help staff work in partnership with carers to keep the patient safe from harm in hospital. Improved partnerships could lead to improved patient outcomes, better staff-carer relationships, and reduced safety responsibility for carers.