Expert perspectives on the active role of patients in their safety: Toward a framework using Delphi methodology

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Abstract

Aims: To develop a framework for Patient Engagement in Patient Safety (PEPS) in hospital.

Methods: The Delphi technique was embraced to involve a group of knowledgeable healthcare experts in the discussion and rating of the components of the PEPS framework. On a 5-point Likert scale, every item was separately rated based on the three aspects, which include applicability, clarity and validity. The PEPS framework included items with 75% or more of participants scoring 4–5 on all three aspects. Items not attaining 75% agreement on the aspects were either changed or discarded, after the group discussion and underwent another round of rerating.

Results: A total of 17 members participated in the consensus-building process. Following two rounds of rating, the consensus was reached on the final framework which consisted of 28 items in four dimensions, relating to healthcare professionals, patients, community, and health system, and three components substituted with patient empowerment, effective communication and patient-centeredness.

Conclusion: The development of PEPS framework is a stimulus to strengthen human resources for health capabilities, sustain a high level of quality patient outcomes, and improve the health system. Further studies to identify strategies are needed for the successful implementation of this framework.

KEYWORDS

Delphi study, framework, patient engagement, patient safety

1 | INTRODUCTION

In recent decades, advances in medical science have led to significant success in the treatment of patients. This has enabled health care systems to effectively treat large numbers of patients in hospitals, daily.¹ The use of complex technologies, new medicines and treatments in modern systems of health care may, however, cause unintended damage due to unsafe care.² The third leading cause of death in the US based on Makary and Daniel's is medical error.³ Death rate estimates from four studies from 2000 to 2008 were used, including one from "US Department of Health and Human Services Office of the Inspector General" and the "Agency for Healthcare Research and Quality." Makary and Daniel's then used patient admission rates in

2013 and extrapolated that, based on 35,416,020 hospitalizations; there were 251,454 deaths due to medical error, which amounts to 9.5% of all deaths annually in the United States.³ A study in 26 low- and middle-income countries showed an 8% occurrence of medical errors, of which 30% resulted in death, with 80% of these deaths preventable.⁴

Patient safety is considered a major worldwide challenge,⁵ becoming a top priority after the Institute of Medicine report was released in 1999: "To err is human: building a safer health system."⁶ Considering the extent of safety incidents in health care systems and their associated costs,⁷ and the nature and extent of the damage to affected patients,⁸ it is important to consider patient safety. High-quality healthcare systems accommodate patient safety, defined