Exploration of student nurses' experiences in practice of patient safety events, reporting and patient involvement.

Abstract

Background/Introduction: Qualified and student nurses remain at the forefront of dealing with, and reporting, patient safety events or incidents. There has been limited exploration of whether and how the patient's perspective is represented by staff or student nurses using formal reporting systems.

Objectives: The overall aim of the study was to explore the student nurses' experiences in practice of patient safety events they were themselves directly or indirectly involved in. This specifically explored the subsequent reporting and inclusion of the patient perspectives that may or may not have taken place.

Design: A qualitative approach to this research was selected using the principles of thematic analysis to analyse data gathered from focus groups of student nurses across all year groups.

Setting: Three universities participated in the study located in the north east, south east and east of England.

Participants: Student nurses from across the year groups attended focus groups

Methods: Following ethical approval and informed consent, participants took part in focus groups within each university setting. Data were transcribed verbatim and analysed using thematic analysis.

Results: Three themes were identified: the benefit of reporting and patient involvement, the barriers experienced by the students in reporting and the support needed to ensure they do the right thing in practice.

Conclusion: Learning for students from patient safety incidents is important and seeking patients' views and perceptions adds to the learning experience. There are however challenges for the student in practice in both reporting and patient involvement. Resources are needed that follow and feed into the student learning alongside a workforce that see the benefit of learning from those we care for.

Key words: Patient Safety Reporting, Patient Involvement, Student Nurse

Background

Patient safety is a term used to describe the collaborative efforts of healthcare providers, systems, services and practitioners to ameliorate the risk of unnecessary harm to patients: a concept that is a significant issue in healthcare (NHS England, 2017; WHO, 2017). Patient safety terminology from World Health Organization, (2009 p 22) classifies an event as *"something that happens to or involves a patient"* with an incident described as *"an event or*

circumstance that could have resulted, or did result, in unnecessary harm to a patient". A near miss is classified as *"an incident which did not reach the patient".* Additionally, the National Patient Safety Agency (NPSA) described an event as *'any unintended or unexpected incident that could have or did lead to harm for one or more patients receiving NHS-funded healthcare'* (NPSA, 2004).

Globally it is acknowledged that there is a need for greater involvement of both patients and families in patient safety (The Health Foundation et al., 2013; Ministers, 2017). Such involvement is needed across healthcare settings in a number of ways, such as patients' retrospective involvement in safety events and incidents, increasing individuals' own patient safety literacy, and the role patients may take in planning for an improved safety culture (The Health Foundation et al., 2013; WHO 2017). These initiatives are set to enhance the potential for new perspectives and insights into safe and effective care.

The call for greater patient involvement in safety has grown (Ahmed et al., 2014; De Brún et al., 2017; The Health Foundation et al., 2013; Vincent, 2002; Ward and Armitage, 2012; WHO, 2017) with some founding positive associations between patient experience and clinical safety, (Doyle et al., 2013). This suggests the inclusion of patient experience data provides an added dimension to understandings of patient safety.

Patients may define safety differently to healthcare professionals however the dimensions they experience have the potential to contribute to our understanding of patient safety events and incidents (O'Hara et al., 2018; Scott et al., 2012). A large multi-site study from three UK NHS Trusts suggested that patients make a valuable contribution to safety reporting where 1 in 10 incidents that were reported met the clinical definition of patient safety (O'Hara et al., 2018). They go on to suggest that there may be an underestimation of safety incidents that fall outside of the clinical definition that offer insight into the unique patient experience and an opportunity to improve safety and experience for the patients.

Nurses remain at the forefront of dealing with, and reporting, patient safety events or incidents (Fisher and Kiernan, 2019) and understand the requirement to report. Those who witness substandard care, however, also consider carefully the potential negative consequences of reporting for themselves and their colleagues (Fisher and Kiernan, 2019; Ion et al., 2016). To add to this, there has been limited exploration of whether and how the patient's perspective is represented by staff or student nurses using formal reporting systems. This is explained in part by O'Hara et al., (2017) as they explored the optimum route for capturing patients perspectives on patient safety experiences. They suggest capturing feedback and views from patients through a facilitated discussion at the bedside often will reveal their concerns about patient safety and caution about restricting feedback through established routes and formats.

Student nurses experience many placement episodes that they feel are related to patient safety, but may find it challenging to raise these issues (Bickhoff et al., 2017; Pearson and Steven, 2009). Although they are the professionals of the future, students are seldom considered and often omitted from discussions about patient safety (Pearson and Steven, 2009; Steven et al., 2014).

It is accepted that students learn in and from practice and role model those around them (Bandura, 1977; De Swardt, 2019; Jack et al., 2017). Student nurses clearly learn much

about patient safety reporting ‘traditions’ from Registered Nurse mentors and more recently with the implementation of the New Standards (Nursing Midwifery Council, 2018) practice supervisors and assessors. The context of this study however, was the mentorship programme whereby shifts while on placement would involve students working with peers and other students across the year groups in addition to their allocated mentor.

Practice conventions may also play a part and as such, the student may adopt certain practices that omit or quash the patient’s perspective. Indeed, traditional ‘technical rational’ practices that privilege professional viewpoints and objectify the patient (Foucault, 1980) may result in the loss of the patient perspective. This could ‘blinker’ both writers and readers of patient safety reports, resulting in missed opportunities to learn from patient experiences and enhance outcomes.

If we are to develop more authentic inclusion of patient perspectives, it is therefore important to better understand how student nurses represent such perspectives, and what influences that representation. Such understandings could inform ways of promoting the inclusion and maintenance of the patient view or re-installing the centrality of the patient perspective.

Therefore, the overall aim of the study was to explore the student nurses’ experiences in practice of patient safety events they were themselves directly or indirectly involved in. This specifically explored the subsequent reporting and inclusion of the patient perspectives that may or may not have taken place.

The authors of this paper were awarded funding by the UK General Nursing Council in September 2018 for a three-phase project designed to develop understanding regarding patient perspectives captured by students in safety reporting. This paper presents stage two of this research, an empirical study exploring student nurses’ experiences in practice of patient safety events they were themselves directly or indirectly involved in and the subsequent reporting and inclusion of the patient perspectives that may or may not have taken place.

Ethical considerations

Ethical approval was gained from the hosting university’s Ethics Committee (Ref 11053) and was then shared and agreed by the other two universities. The nature of the study implies that sensitive information may be uncovered, and it was therefore necessary to ensure that participants were provided with written and verbal information pertaining to the study and that consent was obtained from them. The participants were recruited on a voluntary basis and strict ethical principles were adhered to. It was also noted that there were potential power implications between researcher and participant. It was therefore imperative to make participants aware of the right to withdraw.

Research design

A qualitative approach was selected within a constructionist epistemological perspective, understanding that individuals make sense and meaning as they interact with the individuals

and objects of their world (Blaikie, 2007; Crotty, 1998). This approach is congruent with the research aims to identify and describe the ways in which student nurses represent the patients' views and perspective with regard to patient safety events, and what influences those representations.

Sample and recruitment

At the time of the study the New Standards (Nursing Midwifery Council, 2018) were not in place and as such, students were on placements working with mentors, some may have been working with peers and other students from across the year groups.

A purposive sample of nursing students across 3 universities was used.

A total of five year-group specific focus groups and one individual interview (C2) were undertaken (see table 1). The overall samples consisted of 28 participants.

The year groups represented were BSc (Hons) Nursing Studies/Registered Nurse (Adult) years two to three and BSc (Hons) Nursing Studies/Registered Nurse (Adult) Apprenticeship route (final year). (see table 1)

Each focus group lasted between 35 -45 minutes. The one to one interview lasted 25 minutes It was planned for a focus group but due to circumstances only one participant attended. It was agreed with student and interviewer to undertake the interview. Focus groups had between 2 and 8 participants across the year groups 2 and 3.

Students across the year groups had experienced a wide variety of both hospital and community placements and were at various stages in their studies. Which allowed for a broad context from which to draw on their experiences.

Insert table 1 here.

Table 1: demographic of participants

Data Collection

A literature review was conducted by the hosting university and the university in the south east of England. This informed a semi structured interview guide for all of the focus groups and one interview (C2) that ensured data collection focused on the ways in which students learn to write reports, the meaning they make and take from Patient Safety (PS) episodes and their views on the position of the patient in PS episodes. This guide provided a loose framework allowing exploration of the aims of the study; however, participants were also encouraged to raise additional issues they felt important so as to identify new insights and enrich data collection. Data was recorded using a digital device.

Quality and rigour mechanisms

Drawing on a recent review of published literature ensured relevance and pertinence of the questions used in data collection. Individual and group data analysis enabled checking and

confirming of emerging analysis and findings. Data collection across sites was undertaken to enhance the potential transferability of findings and avoid the limitation of location specific findings. In addition, a reflexive approach was employed to ensure transparency throughout the research process around researcher position and the decisions made (Alvesson and Sköldberg, 2000).

Findings

Participants' views on patients' engagement with patient safety issues.

Overwhelmingly, participants did not question the importance of patients' involvement and engagement in safety episodes, many alluding to consequent benefits around openness and transparency. Others suggested there were challenges around acuity and mental capacity for some patients in taking on board the required information. Participants also recognised there were external barriers to patient involvement that would need greater support and education for staff.

- **Benefit to patient engagement.**

  "We should be asking our patient: "Are you happy? How do you feel?" (A2).

Participants acknowledged that there would be a significant benefit to practitioners from understanding the patient perspective of an incident and taking the learning points from it.

> *" I think it would be more of an eye-opener for those who do read and think: oh, if that's what they've said, then…What are you going to do about it?"* (A2)

Some recognised their responsibility to inform patients and the opportunity that this would provide them for personal learning and development.

> *"I think it's really important just for the duty of candour to tell patients if there have been accidents, like my patient, just telling him about his pressure sore, like reporting that but I think, actually telling the patient and being open with them is very important for near misses because I think it really sticks with you when you have to tell the patient something like that…"* (C2)

> *" the patient wasn't involved… reflecting on it now, I feel a bit uncomfortable about that."* (C4)

This engagement with the patient, and the learning taken from the engagement, has the potential to change behaviours. It could thus be a powerful tool in personal development and, ultimately, cultural change.

> *"I don't wanna go through it again, so I would hope that it would help with the near misses because it's just you think about it more.. ? you think of the personal experience, it's not like this subjective thing that hasn't happened to you, it's personal, uhh, that was nasty, that's not that have is happening again, so, yeah, it think it would help, yeah."* (C2).

It was, however, noted that there were areas where the culture of blame was present and as such had the potential to curtail both reporting and consequent patient involvement.

> *"but, when it's [a report] against like…when the patient fell, I hate that because that's like, you should have been there but it's not but it feels like it."* (C3)

> *"So, I do [report], I don't avoid it but I always feel like, I'm telling, so, I don't personally like filling them in, I always fill them in because they're important but I feel like it's a sign of blame because like adding the witnesses and stuff, I don't know, I just don't like it but I do it like you do it.* (C3)

- **Barriers to patient engagement**

Patient acuity and mental capacity was alluded to as a challenge in securing patient involvement, with relatives and carers often being engaged in addition to, or instead of, direct patient engagement. There did not appear, however, to be a consistent approach to patient involvement in different clinical settings.

> *"[the] patients have dementia so I don't think that we were very um.. we didn't really explain the process to them, it was more telling their relatives."*

> *"but with this patient, I explained to him, I had to explain to him because he was very compos mentis, I was like, you have pressure sore, I explained that to him and also his wife… I think that was probably more patient centred because I really explained it to him."* (C2)

> *"I don't think she was aware that we had [reported] it. She wasn't aware that a [report] had been done, and even been part of the process."* (C4)

Some participants felt that involving the patient would be difficult within the time constraints: an unknown time commitment impacting on their workload.

> *"But I think… they wouldn't have the time to go to the patient, explain, go through with them about the situation and trying to comfort them…"* (C3)

This participant went on to say that staff may also be reluctant to speak with patients for what that may mean for the implicit trust that exists within the nurse-patient relationship.

> *"And like the staff member saying that 'oh, that was me' because like, no one likes to admit that they're wrong, they've caused the incident so…* (C3)

Participants also recognised that patients may be reluctant to voice their concerns for fear of the implications this may have with respect to their future care.

> *" … what you've got to think is: a lot of patients are coming back for follow-ups, so they're frightened in case they say something bad that they'll be tret [treated] differently."* (A2)

Participants recalled times when formalised reporting of a patient safety episode didn't happen. In some cases, reporting to the nurse in charge was perceived as all that the participant needed to do at the time. Subsequent reflection on the event provided participants with an opportunity to see things differently.

> *"the patient kept [being] tilted when they were being washed [by] the care assistant …they really would make me uncomfortable… I would walk in… and see this was still happening when I'm not present so I had to report that to the nurse in charge…We didn't like [report] or anything formal, just me telling the nurse and her going back to the care assistant was enough to hopefully sort that. So, yeah, that was my experience of my patient's safety."* (C2)

For this particular participant there was no certainty that the issue had been resolved but she held on to a notion that her contribution was part of a wider picture and thus had faith that the right thing would be done. This scenario provides a dilemma for the student as avoiding formal reporting almost permits the non-involvement of the patient to occur and continue. It is therefore worth considering how the student gets support in managing the situations where patient involvement could be a powerful narrative to improve care

- **Support for students getting patient engagement**

Participants expressed concerns around how to inform, involve and disclose information to the patients and how to communicate such an approach to them, identifying that there was a need for further training in this respect.

> ***"****Maybe just some brief training... but just an overall training, I think, would be helpful, to just discuss that.... you're not the world's worst person, like to try to help that guilt that you might feel…and stuff or having to discuss like a patient safety experience but I would think it would be helpful to kind of know that it is an universal thing that things happen to people, good nurses as well as bad."* (C2)

This participant also concluded there was support at a clinical level from mentors and more senior staff but that there was also a need for training in a wider sense.

> *"that is something that you'd be supported when you do it um.. like your nurse in charge or if you are the nurse in charge so like you know, your ward manager."* (C2)

Participants recognised there were other ways of getting support for some of the more challenging areas about which they had concerns. When challenging or dealing with the behaviours that appeared to be part of culture and practice, some participants were very clear on their responsibility to ensure future students did not have the same experiences albeit their reporting of such incidents was often towards the end of their placement for fear of failing placement.

> *"… we did feed it back to both somebody at the university and the placement facilitator and thankfully, I think the next students at the same place are having a much better time. ….So they've obviously taken onboard what [was] said."* (A2)

> *"but I think that fear is there; you don't want to fail a placement and you're worried that: if I ruffle a few feathers, we waited 'til like the end of the placement because of that reason".* (A2)

The participants also recognised the consequences of a blame culture in a situation where they feel no support is available for them.

> *"if people feel like they're going to be supported from that then I don't think they'll be so like trying covering it up, which is then actually worst thing that you could do when something like that happened so, yeah."* (C2)

Participants therefore understood the notion of doing the right thing and valued any support provided in helping them do so. They also understood the consequences for overall patient safety when there is a culture of blame and limited support.

Discussion

Involving patients in their care is a central premise in contemporary healthcare (DoH, 2012), with acknowledgement that patient involvement in patient safety is a way to ensure safe and high quality care (Ringdal et al., 2017; WHO, 2017). The process of engaging patients with patient safety needs to take account of patients' knowledge and willingness to get involved in patient safety (Duhn and Medves, 2018; Schwappach et al., 2013) and should also consider patients' acuity (Rainey et al., 2015). Engagement is however a shared responsibility between nurse and patient that requires organisations to provide a culture whereby there is opportunity for this concept to be embraced (Bergerum et al., 2019; Skagerström et al., 2017).

Furthermore, De Brún et al's., (2017) study explored barriers and facilitators to patients providing feedback on safety. They proposed that there are three stages to effective engagement with patient feedback: how the patient conceptualises safety, what process or mechanism there is for feedback and finally how this feedback will contribute to learning and change. They suggest patients need to understand all three areas in order to be engaged with the process. It is acknowledged, however, that healthcare is complex and just focussing on one aspect of patient engagement may compromise the ways in which patients and their carers contribute more widely to their care (Braithwaite, 2018; O'Hara and Lawton, 2016). It has also been suggested that much of the debate and discussion around patient involvement may not take account of variation in context. Whilst acknowledging the importance of the individual patient narrative, this can pose challenges in terms of bringing about wholesale change within a broader healthcare setting. To achieve such change, flexibility and tolerance of variation may be of benefit (Braithwaite, 2018; O'Hara and Lawton, 2016), although this requires both commitment and prioritization from frontline staff and leaders alike (Fischer et al., 2018). It is therefore concluded that patient engagement is complex and has many determinants that play a part.

Participants agreed that the formal reporting of patient safety incidents sometimes did not happen, a phenomenon documented in the literature (Anderson et al., 2013). Involving patients in patient safety reporting was additionally not viewed by some participants as common practice. This lack of patient involvement is also recognised within the literature (Archer et al., 2017; Kronman et al., 2012).

Many of the participants, however, acknowledged the benefit of seeking patients' views and perceptions of patient safety incidents. Participants particularly alluded to the increased learning potential of such engagement for themselves as students. They also saw how this learning would benefit others within the care team. Indeed, work based or work placed learning is well established and recognised as a concept that helps contribute to student experiential learning (Eraut, 2002; Murray, 2018). The consequence of seeing an incident

from the patients' perspective brings about a greater human reality for the students than a series of patient safety data or forms.

The literature often identifies a difference between what the patient sees or understands as a patient safety episode and that reported by clinical staff (Fitzsimons and Cornwell, 2018; Travaglia and Braithwaite, 2009). This refocussing on what patients view as being important to them adds to the learning taken from others' lived experience that will ultimately contribute to the act of caregiving (Finch, 2004). Andersson et al., (2015) suggest that many studies have focussed on physical harm than emotional impact. Participants in the current study had good understanding of physical harm incidents such as falls, medication errors and tissue injury but did note that there would be benefit in gaining patients' perceptions on the emotional impact of patient safety incidents.

The concept of beneficence and 'do no harm' (Beauchamp and Childress, 2008) was also alluded to by participants, who were aware that beneficence goes beyond the immediacy of patient safety and should therefore encapsulate timely and appropriate reporting. The implicit tension between beneficence and the act of disclosure of a patient safety incident needs further understanding. How the student manages this tension in practice will need recognition, ongoing support and guidance from both clinical practice and educational establishments if patient views are to be successfully incorporated into reporting systems and processes.

There is an understanding that health care delivery is complex (Braithwaite, 2018; O'Hara et al., 2019) and nurses face challenging ethical situations on a regular basis (Kleemola et al., 2020). Participants acknowledged that the activity of formal reporting was sometimes seen as a difficult thing to do as it may not be viewed by others as important to the ensuing care after a patient safety incident. Bickhoff et al., (2017) describe the need for support to students when they are faced with situations where, although they understand the correct course of action, they either become passive recipients or actively engaged in poor practice. Previous studies have identified that there needs to be greater emphasis on patient safety within the undergraduate nursing curriculum. Considering the often limited flow of patient safety information between clinical practice and higher education establishments (Steven et al., 2014), it could therefore be concluded that at an educational level there needs to be improved information flow and preparation for moral courage in students undertaking reporting that includes patients' views. Bickhoff et al., (2017) also conclude that if students are not encouraged and supported to do the right thing at the right time they will continue to suffer moral distress that will impact on their health and wellbeing.

The trusting relationship between patient and nurse may be impacted by the disclosure of a patient safety episode. The domains of trust, as identified by Hall et al., (2001) and Ozawa and Sripad, (2013) are: communication, honesty, competence and confidence. Dinç and Gastmans, (2013) literature review identified that trust, whilst an essential element in the dynamic of the nurse patient relationship, is fragile and susceptible to influences that can variously break or repair it. Trust may be shaped by previous experience of healthcare and is also related to nurse competence and caring qualities (Dinç and Gastmans, 2013; Ozaras and Abaan, 2018). Thus, a patient safety disclosure that compromises this trust may have impact upon the trusting relationship. One may argue that this may have a part to play in some nurses' reluctance to involve patients in reporting patient safety episodes. It is therefore suggested that there is a tension between patient engagement in patient safety incidents and the management of maintaining a trusting therapeutic relationship. Consideration must therefore be given as to how this engagement and disclosure takes

place. There will be a need for highly skilled individuals to navigate and support patients through disclosure and to ensure that trust is not disproportionately damaged.

Limitations of the research

This study is limited to the student nurses from 3 participating universities undertaking BSc (Hons) Nursing Studies/Registered Nurse (Adult) years one to three and BSc (Hons) Nursing Studies/Registered Nurse (Adult) Apprenticeship route (final year) thus limiting the data to Adult field of nursing. The study also did not take patients' views and perceptions into account.

Trustworthiness and credibility were achieved through detailing and sharing the processes and how the analysis was to be conducted. This analysis and sense checking involved establishing a critical dialogue between three senior academics to ensure the influence of pre-understanding was minimised.

Conclusion

Learning from patient safety incidents has significant merit in contemporary healthcare where the refocussing on patient centrality is fundamental to high quality, safe and effective patient care. The premise of seeking and securing patients' views and perceptions of patient safety incidents is too simplistic in its current form and requires a rethink as to how the current educational and practical experiences of the student can be supported and enhanced to facilitate a shift in reporting activity. Resources are needed that follow and feed into the student learning, alongside a workforce that appreciates the benefit of learning from those we care for.

Further research that explores how patients and students engage and interact in the disclosure of patient safety incidents in a clinical healthcare setting would add to our understanding and may point towards specific educational actions and outcomes that would be beneficial.

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Data / University	Focus group details		Gender	Individual interview
	FG identifier	Details		
1. North East of England (UNEE) Lead university	A1 A2	Year 2 (8 participants) Year 3 Apprenticeship (6 participants)	7 female 1 male 6 female	0
2. East of England university (UEE)	B1	Year 2 (4 participants)	4 female	0
3. South East of England university (USEE).	C1 C2 C3 C4	Year 1 (5 participants) Year 3 (1 participant) Year 2. (2 participants) Year 3 (6 participants)	4 female 1 male 1 female 2 female 6 female	0 1x Year 3 student 0 0
Combined sample by Student year group	Year 1: 5 Year 2: 14 Year 3: 13 Total Participants: 32		Gender: 30 female 2 male	

Table 1: demographic of participants