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New 10-year patient safety analysis highlights areas for improvement in acute medical units

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Recommendations from a new 10-year analysis of patient safety incidents in hospital acute medical units across England and Wales include the introduction of electronic prescribing and monitoring systems, checklists to reduce diagnostic errors, and an increased presence of senior clinicians and pharmacists overnight and at the weekends to reduce the vulnerability of less experienced staff.

The research, by Cardiff University and University College London, published today in the *Journal of the Royal Society of Medicine*, is the first analysis of all the severe harm and death incident reports occurring in acute medical units in England and Wales. It shows the most common incident types were diagnostic errors, medication-related errors and failures in monitoring patients.

Acute medical units were introduced in 2004 to relieve pressures on emergency departments and improve patient outcomes, but little is known about patient safety incidents occurring in the units.

The researchers analysed 377 acute medical unit incidents reported to the National Reporting and Learning System for England and Wales which led to severe harm or death between 2005 and 2015. Diagnostic error was the most common incident type, with delayed diagnosis the most common diagnostic error, and cancer the most commonly missed diagnosis.

The research shows that patients were at a higher risk of patient safety

incidents when there were multiple handovers between teams; transfers between wards; and the out-of-hours settings including during the night.

Lead researcher Dr. Andrew Carson-Stevens, Clinical Reader in Patient Safety and Quality Improvement at Cardiff University's School of Medicine, and lead for patient safety research at PRIME Centre Wales, said: "The reports in this study came from frontline healthcare professionals over a 10-year period and our detailed analysis highlights where acute medical units can review their existing systems to ensure they are as safe as possible." He continued: "The learning from these incident reports represents an invaluable opportunity to improve the safety of acute medical units for future patients. The NHS also stands to improve overall staff well-being by using the insights to design work environments that maximise their performance and mitigate risks resulting in unsafe care outcomes in this often high-pressured care setting."

One of the themes running through the incident reports was the dependence on individual people for patient advocacy to remind staff about investigations or referrals. Another of the researchers, Dr. Sarah Yardley, of University College London, said: "Patients who were unable to self-advocate due to their illness or other vulnerabilities were often overlooked due to system pressures and may be most at risk."

More information: Alexandra Urquhart et al, Learning from patient safety incidents involving acutely sick adults in hospital assessment units in England and Wales: a mixed methods analysis for quality improvement, *Journal of the Royal Society of Medicine* (2021). DOI: 10.1177/01410768211032589