

PSI 3: Patients experiencing Adverse Events	
Origin: PSI by SimPatIE	
Dimension	Description
Description of Specific Aspects of Patient Safety	The ultimate goal is to achieve the best care and outcome for patients each time they are in touch with the health care system. The frequency of adverse events is cause for serious concern. A comprehensive approach to reduce adverse events involves not just health care organisations but patients as well as patients are an important source of observations and information about adverse events, though. All though it is a known fact within patient safety experts that patients comprehend adverse events as errors, patient's experiences of adverse events is considered important as a source for identifying areas for improvement. Thus patient's experience of adverse events is an important measure of patient safety.
Aim of the PSI	This PSI aims at surveillance of patient's experience of the presence of adverse events (e.g. in diagnosing, medication, procedure, and communication).
Level of Determination of Patient Safety	Safety is assessed at the aggregated patient level.
Source(s)	This PSI is derived from the section on patient safety of the Danish national patient survey: Patient's experiences in hospital (9).
Extent of Clinically Testing	<p>By using a questionnaire attitudes and responses to adverse events were investigated from the patient's and the staff's point of view. Patients were asked about their experiences with adverse events and staffs management of adverse events. Comparison of responses to the same questions was made between the two groups. Twenty percent of patient had experienced minor adverse events and eight percent large adverse events during hospitalisation (9).</p> <p>Another Danish study using mailed questionnaires estimated the incidence of medical errors; also the extent of agreement between patients and staff of the type of error was investigated. Errors were described in free text by informants and rated in categories by a risk manager. Of the staff 44% had experienced an error within the last three months in ambulatory or in-patient care, whereas 13% of the patients had experienced an error. The most frequent error experienced by staff was: "wrong medicine" and by patients "delayed diagnosis". By the descriptions the risk manager found that 44% of the patient reported errors could be classified as dissatisfaction. The researchers concluded that patients typically find it difficult to distinguish between an error and their dissatisfaction, highlighting a need for firm criteria if patients are to report errors as a basis for improvements. Comparison of error rates between patients and staff – and indeed</p>

	<p>between hospitals - will be misleading until these criteria are reliable and validated (10).</p> <p>This PSI has not been clinically applied.</p>
Evidence of Clinically use of Standards	No evidence of clinically use of standards was found.
PSI category	Institution-Wide PSI.
Data definitions	Number of patients experiencing an adverse event per 1000 discharges.
Numerator Description	Number of patients experiencing an adverse event during hospitalisation.
Denominator Description	Number of patient's discharges from hospital
Data Source	Patient's Experiences (Satisfaction) Survey.
Identifying the institutional context	The qualitative and quantitative consequences of adverse events make this PSI important in quality improvement policies.
Care Setting	The PSI applies institution-wide.
Professionals Responsible for Health Care	All authorised health care workers.
Lowest Level of Health Care Delivery Addressed	Individual clinical department.
Allowance for Patient Factors	No risk adjustment described.
Stratification by Vulnerable Populations	No stratification.
Standard of Comparison	No specific time standards given, but comparison every second year has shown to be good.
Scoring	Scoring according to the manual of the Patient's Experiences (Satisfaction) Survey.