NIHR Greater Manchester Patient Safety Translational Research Centre

NIHR Greater Manchester PSTRC

Plain English Publication Summary

Publication: Capturing Patients' Perspectives on Medication Safety: The Development of a Patient-Centered Medication Safety Framework

Publication details (Vancouver format)

Giles SJ, Lewis PJ, Phipps DL, Mann F, Avery AJ, Ashcroft DM. Capturing Patients' Perspectives on Medication Safety: The Development of a Patient-Centered Medication Safety Framework. J Patient Saf. 2020 Dec;16(4):e324-e339. doi: 10.1097/PTS.0000000000000583. PMID: 30882613; PMCID: PMC7678656.

What are the most important findings/conclusions in this paper? Why are they important?

There is currently no standard way of recording patients' views on the causes of medication errors. The P-MEDS framework and checklist have been produced as part of this study and can be used to capture these views. The information gathered from PMEDs could be used alongside existing methods to help prevent future medication safety incidents.

What did you do?

We asked 106 members of the public, patients, and carers to take part in 18 focus groups. The focus groups were recorded, and then analysed. Researchers looked for common themes or opinions, which were then divided into categories. This kind of analysis builds what is known as a thematic framework.

A patient and public involvement group was also set up to help the research team with all stages of the research study, including deciding which questions to ask at the focus groups, helping with the analysis of the data, and producing a patient-centred medication safety framework (also known as PMEDs).

Why did you conduct this research?

Medication safety incidents are common in primary care. It is important to understand what causes these types of incidents, particularly from the point of view of patients and the public. Frameworks can help us to understand more clearly what the main causes of medication safety incidents are. A framework that is developed from the patient's perspective can help us to do this. The aim of this study was to develop a patient-centred contributory factors framework (also known as PMEDs) to help us understand medication safety incidents.

What was known before your paper was published?

We know that several different models have been developed to help us understand the things that contribute to patient safety incidents in healthcare. Most of these models are aimed at, and developed with, healthcare professionals. They are also known to cover a wide range of patient safety issues. We also know that patients' views of safety have usually been overlooked, but that patients are able to identify the causes of medication safety incidents and are happy to provide feedback on the safety of their care. Patients are also known to offer a different and important view on patient safety compared to healthcare professionals.

As far as we know, nobody has looked at patient points of view about the causes of medication safety incidents, or to develop a model to help us understand patients' views. Because of this, we set out to develop a patient-centred contributory factors framework of medication safety issues (also known as PMEDs). This could also help to involve patients in the monitoring of medication safety incidents, as well as during the investigation process.

What is next? What is the potential impact of the work in this paper? What will change as a result of this paper (or the study it describes)?

The PMEDs framework is currently being tested in community pharmacies as part of the Medication Safety theme within the GM PSTRC. It has the potential to provide a way for patient views on the contributory factors of medication safety incidents to be captured. It could be used with other existing ways of making sure the patient view is considered during the investigation and prevention of medication safety incidents.

Does this paper link in to a particular study / project? If so, please summarise the study and explain how this paper has improved understanding, or will move the study forward.

The study took place in the 2012-2017 GM PSTRC, and it links with the Medication Safety theme in the current GM PSTRC.