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Plain English Publication Summary

Publication: Regulating Patient Safety during Hospital Discharge: Casting the Patient Safety Commissioner as the Representative of Order

Publication details (Vancouver format)

Moore VL. Regulating Patient Safety during Hospital Discharge: Casting the Patient Safety Commissioner as the Representative of Order. Medical Law International 2021;

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

In this paper, I argue that the role of the new Commissioner for Patient Safety should be extended to include more than just the safety of medicines and medical devices. This is because when it comes to patient safety, there are many factors outside of medicines and medical devices that can pose a threat to patients. For example, one threat is in the processes around transitions of care, such as when a patient transfers from hospital back to their home. If the role was extended, the Commissioner would be able to work between regulatory bodies, making sure patients are listened to, and that critical safety reports do not get stuck, missing the opportunity to make a difference.

What did you do?

I used the idea of 'liminality' to explain why the Patient Safety Commissioner could make an important difference to the safety of hospital discharge. Liminality simply means being 'in-between'. People can be liminal. For example, when a person is engaged to be married, they are experiencing this in-betweenness as they transition from unmarried to married. They are neither unmarried nor married when they are liminal. As well as 'liminal' people, you can have 'liminal spaces' – such as the corridors between offices.

Liminality was a useful way of exploring what is happening in healthcare regulation. Liminal spaces exist between the regulators who share responsibility for ensuring patients are safety discharged from hospital. Often, things which could improve safety, such as reports highlighting previous failings, get stuck and become liminal objects, so they are unable to make a difference.

Why did you conduct this research?

This work is part of my PhD research, which examines the quality of responses from regulatory bodies to patient safety incidents that relate to hospital discharges. The role of regulation in improving patient safety during hospital discharge has been under-researched, so it's a great opportunity to see how regulation could really make a difference.

What was known before your paper was published?

Healthcare regulators are responsible for making sure that patients are safe, and for taking actions to improve patient safety issues. Although previous research has shown that patients who are discharged from hospital are at an increased risk of harm, regulators haven't taken much action in response.

In a previous article I showed how the method of regulation used by regulators is not as effective as it should be, partly because of the large number of regulators sharing responsibility in the NHS. This paper aims to present a possible solution to this problem.

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)?

It is hoped that the paper will inspire researchers who are interested in regulation theory and patient safety to do more research into hospital discharges.

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.

NA