ABSTRACT

Objectives Patients and caregivers are the primary stakeholders in ambulatory safety, given they perform daily chronic disease self-management, medication administration and outpatient follow-up. However, little attention has been given to their role in adverse events. We investigated the role of patient and caregiver factors and challenges in ambulatory safety incident reports from a Patient Safety Organization.

Methods We conducted a mixed-methods analysis of ambulatory incident reports submitted to the Collaborative Healthcare Patient Safety Organization, including 450 hospitals or clinic members in 13 US states. We included events that had patient and/or caregiver involvement, socioeconomic and clinical factors that may have contributed to the event. Two members of the team independently coded patient/caregiver factors, with dual coding of 20% of events. We then conducted a 'frequent item set' analysis to identify which factors most frequently co-occurred. We applied inductive analysis to the most frequent sets to interpret themes. Our team included a diverse stakeholder advisory council of patients, caregivers and healthcare staff.

Results We analysed 522 incident reports and excluded 73 for a final sample of 449 events. Our co-occurrence analysis found the following three themes: (1) clinical advice may conflict with patient priorities; (2) breakdowns in communication and patient education cause medication adverse events and (3) patients with disabilities are vulnerable to the external environment.

Conclusions Ambulatory safety reports capture both structural and behavioural factors contributing to adverse events. Actionable takeaways include the following: improving clinician counselling of patients to convey medical advice to elicit priorities, enhanced education regarding medication adverse events and expanding safety precautions for patients with disabilities at home. Ambulatory safety reporting must include patients in reporting and event review for better mitigation of future harm.

BACKGROUND

Patients and family caregivers are primary stakeholders in ambulatory safety, yet are rarely acknowledged or involved in ambulatory safety efforts. Patients and caregivers are responsible for medication self-administration, care coordination between different clinics and specialty sites, and monitoring their own safety between visits. For example, >20% of preventable ambulatory adverse drug events were related to Medicare patients’ own medication self-administration in retrospective reports. Leaders such as Agency For Research in Healthcare Quality and the National Academy of Medicine encourage enhancing patient and caregiver involvement in ambulatory safety improvements.

Despite their key role in ambulatory safety, prior studies of ambulatory adverse events rarely address the patient and caregiver role. Some analyses invoke ‘patient factors,’ but little is known about how patients and families’ behaviours impact safety in outpatient settings. Adverse event reporting is a commonly used mechanism for identifying safety events, but these reports are typically provider-initiated or staff-initiated and focus on their perspective, excluding attention to how the patient and caregiver were involved in the event. Patient safety leaders have discussed the difficulty of integrating patient involvement into existing safety programmes and existing data collection methods.

Many ambulatory sites within hospital-associated networks in the USA share their adverse event reports in aggregate databases maintained by Patient Safety Organizations (PSOs). PSO data are one of the few large-scale sources available currently for ambulatory adverse event data. While some studies have assessed ambulatory safety in PSO data, little attention has been given to the patient and caregiver factors implicated in these ambulatory safety reports. We sought to identify what patient and caregiver factors are identified in existing ambulatory reports in a multistate PSO. By analysing existing event reports, we can better understand what patient and caregiver perspectives are already
observed by providers and staff, as well as provide insights into what gaps should be closed for ambulatory safety monitoring and review. By utilising stakeholder input in analysing these reports, we also demonstrate how patient engagement can be leveraged to analyse existing patient safety data.

METHODS
Data source and sampling
We conducted a qualitative analysis of a subset of events from the Collaborative Healthcare Patient Safety Organization (CHPSO) database. CHPSO is located in Sacramento, CA, and is a federally designated PSO comprising of 450 member hospitals across 13 US states, with 1.5 million total safety incidents to date.9

Our sample was composed of de-identified incident reports imported from CHPSO labelled as ‘outpatient’ that occurred between the dates of May 2012 and October 2018. We included events in primary care, outpatient specialty care, dialysis, home/community, behavioural facilities and residential nursing facilities. We excluded events occurring in the emergency department or inpatient setting, events too confusing and events lacking adequate details. CHPSO’s database had >37 000 total ambulatory events. Of those, we randomly sampled 2701 events (online supplemental file 1; Consolidated Standards of Reporting Trials (CONSORT) diagram); this has been described in a prior study.10 Our sample included all events labelled as with ‘moderate harm’, ‘severe harm’ and ‘death’, as well as 200 ‘missing harm’, 200 ‘no harm’ and 600 ‘minor harm’ events. These events were coded with a variable to capture if patient or caregiver challenges were mentioned that could have contributed to the event in question. For example, if a patient experienced hyperglycaemic due to being unable to afford insulin, we would respond ‘Yes’ to ‘Were there specific challenges experienced by the patient, family and/or caregiver that could have accidentally contributed to this event?’

Analysis
In this mixed-methods approach, we first conducted a content analysis of all events with a patient or caregiver challenge implicated in the event.11 Two study team members (AES and BH) reviewed 10% of events and developed a codebook comprising specific patient or caregiver challenges represented in the events (such as ‘competing priorities’ or ‘socioeconomic factors’). The individual coding was conceptually congruent, and codebook development did not entail significant disagreements between the two coders. The two team members dual coded 20% of the sample and the remainder independently. When a new patient/caregiver challenge arose in the sample, we updated the codebook and reapplied it to the remainder of the sample. We then conducted a quantitative ‘frequent item set’ analysis of these patient/caregiver challenges. In other words, we computed frequencies of individual patient/caregiver challenges, as well as frequencies of co-occurring pairs and triplets of patient/caregiver challenges, using the arules package in R.12 The group met as a team to review the most frequent triplets and pairs of co-occurring patient/caregiver challenges in the sample in descending order, investigating the narrative events described in these clusters to explore conceptual links. To choose our final themes, we selected the most frequent clusters that did not share the same patient/caregiver challenges; one of the most frequently occurring triplets and two of the most frequently occurring pairs. We iteratively reviewed the narrative events comprised in the clusters, applying an inductive qualitative approach,13 to develop these final themes.

Patient and public involvement
The study question and design were informed by prior work based on direct ethnographic observations of patient and caregiver experiences in self-management of high-risk conditions and medications.14 The study was co-conducted with involvement from a Stakeholder Research Advisory Council of patients, caregivers, primary care clinicians, nurse, medical assistant and pharmacist. The group was recruited from the local public health network. The Stakeholder Council met five times over the course of the study period, with 10–12 members per meeting, with ad-hoc email and telephone communication between meetings. Stakeholders received a gift card reimbursement for their time. The Stakeholder Council was involved throughout the conduct of the study. First, they shaped the data abstraction phase, and provided some of the categories of ‘patient/caregiver factors’ in the coding process. For example, they suggested the term ‘competing priorities’ to encapsulate when patient decisions differed from a healthcare recommendation. They reviewed a subsample of events to confirm the codebook corresponded with the adverse event data. The council then reviewed preliminary themes, provided input on interpretation of themes and made the final decision on the themes included in final results. Members provided edits to the article as well as recommendations for dissemination of results; all members have access to study results.

RESULTS
Of 2701 sample events manually coded, individual team members (AES, JB and JY) identified 522 in initial review mentioning patient or caregiver challenges. Afterwards, a separate team member (AES and BH) reviewed selected events to confirm they met inclusion criteria and to fulfill dual-review. This excluded 73 events which did not meet inclusion criteria, leaving a final sample of 449 events. A full tabulation of types of patient and caregiver factors and challenges are listed in table 1 with examples. These included comorbid medical conditions (n=109, 24%), lack of adherence to clinical recommendations (n=97, 21.6%), mental health (n=73, 16.2%), disability (n=68, 15.1%), incorrect administration of medications (n=68, 15.1%), caregiver factors (n=53, 11.8%), communication

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Theme 1: Conflict between clinical advice and competing priorities

We found co-occurrence with events related to patients not proceeding with clinical recommendations and competing priorities. Examples included declining to go to the emergency room when reporting concerning symptoms, signing out of a clinic ‘against medical advice’ or requesting termination of a recommended treatment: Patient requested that her dialysis time be shortened today related to ‘immigration issues’. Reminded patient about risks and complications associated with cutting treatments & missing treatments and she verbalized an understanding.

Examples of competing priorities included family obligations, transportation barriers and housing issues. Those reporting competing priorities in opposition to clinical recommendations provided varying levels of details in the documentation. Some provided details of elicitation of details of the patient priorities, as well as counselling, while others simply documented when a patient was recommended to go in for care. Patient approached writer at the beginning of the shift ‘I think I need to go home’ ‘my father needs me’ ‘he is sick’ writer spent time with patient listening to her concerns, patient was encouraged to stay, and focus on her recovery, patient verbalized understanding … patient is determined to go home ‘i am ready’ ‘I’m done detoxing’ patient stated not craving and just wanting to home to see her father.

Theme 2: Communication breakdowns contribute to medication adverse events

In these events, there were gaps in communication to convey relevant information to patients and families, including awareness of drug–drug interactions, drug events related to dietary intake or fasting prior to a procedure and changes sent to pharmacies that were not communicated with patients. Medications commonly implicated included medications considered high risk for outpatient medications including opioids, anticoagulants and hypoglycemic agents.

Components of education and communication breakdowns were multifactorial. In some cases, a lack of patient understanding of a regimen, dosage or drug allergy profile resulted in a medication adverse event: Received critical INR of 12.52 from the lab. Called and spoke to pt. Patient reports no problems with bleeding or bruising. Pt was confused about dosing and could not verify how much he takes per day. In other cases, there were prescription or dosage changes made that were not communicated to the patient, or drug–drug interactions with over-the-counter medications that patients were not aware of: Patient comes

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Table 1  Frequency of patient/caregiver factors mentioned in patient safety reports

| Patient/Caregiver factor       | Factor definition                                                                 | Frequency (n=499) |
|-------------------------------|----------------------------------------------------------------------------------|------------------|
| Comorbid conditions           | Other medical conditions not related to the issue reported about that contributed to the incident | 109              |
| Following clinical recommendations | Issues that arise when there is deviation from clinical recommendation       | 97               |
| Mental health                  | Emotional, behavioural, or psychological distress involved in incident.           | 73               |
| Disability                    | Physical or cognitive limitation involved in incident                           | 68               |
| Administration of medications | Safety events that arise from issues with medication administration (eg taking too much or too little) | 68               |
| Caregiver factor              | Caregiver actions or inactions that may have accidentally contributed to the event | 53               |
| Miscommunication              | Communication breakdown (unable to reach patient, information not getting transmitted; patient/caregiver following up on issue) | 48               |
| Environment or equipment issue | Safety issues with equipment or physical environment directly contributing to the event | 43               |
| Patient education             | Issues or barriers related to the healthcare team providing adequate education about disease management, medication management, practice policies or treatment protocols | 23               |
| Reporting clinical information | Incidents where relevant clinical information was either intentionally or unintentionally withheld from the healthcare team (did not report symptoms or pertinent medical history) | 20               |
| Socioeconomic factors         | Issues involving insurance, income, transportation, employment or housing       | 17               |
| Competing priorities          | Situations in which patient priorities, values, commitments, obligations are competing with medical recommendations | 15               |
| Substance use                 | Safety issues involving use or misuse of pain medications, alcohol and/or drugs   | 15               |
| Self-care/nutrition           | Situations that involve patients neglect of their physical or emotional health (skipping meals, not sleeping) | 12               |
The patient and caregiver factors identified in this dataset are both ‘structural’, such as disability, mental health or socioeconomic factors, as well as ‘behavioural’, such as following clinical recommendations, self-administration of medications and competing priorities. Both ‘structural’ and ‘behavioural’ factors interacted in adverse events. For example, a patient may not be able to ‘follow clinical recommendations’ due to a socioeconomic factor, or a patient with a disability was then vulnerable to a fall when their caregiver didn’t monitor them. Analysis of ambulatory adverse events with an emphasis on the patient and caregiver perspective reveals how difficult it is to elicit if an event is ‘preventable’ or ‘non-preventable’, which is usually standard in root cause analyses. For example, if a clinic had implemented patient education protocols regarding anticoagulation, would a patient have still combined warfarin with over-the-counter medications leading to a bleeding event? If all patients using a walker had a home safety evaluation, would they still have tripped on their equipment and fallen? Without the patient perspective on both the structural and behavioural factors at stake, we are unable to effectively identify and implement solutions to mitigate adverse events.

Our analysis identified conflict between competing patient priorities and clinical recommendations as a prevalent theme, signalling the need for better communication when concerning symptoms arise. Clinicians should elicit patient and family priorities, values and preferences when giving clinical guidance and options, ideally in advance of a collision between patient safety and other patient priorities. The frequency of this factor in this dataset may also represent a defensiveness or legalistic aspect when staff enter adverse event reports. Providers or staff may feel a need to document their cautionary advice such as provision of emergency room precautions. This defensive verbiage is common in adverse event reports: one report from the UK found up to 36% of adverse events in primary care included blame of others.16 Our analysis supports the redirection of patient safety efforts towards a more non-incriminatory framework based on inclusion, learning and making amends.17–20 Using this lens, we can instead reframe events involving patients going ‘against clinical advice’ as a mismatch between clinician incentives to avoid the worst case scenario and the realities of patient personal priorities.

Our sample uncovered links between lapses in clinician–patient communication and medication adverse events. These involved known high-risk medication classes of opioids, hypoglycemics and anticoagulants. Despite calls to action to prioritise these drug classes;21 these medications continue to cause notable harm in outpatient settings, signifying the need for novel medication safety strategies. Inadequate patient education has been proven as a cause of medication adverse events, particularly among elder adults with five or more medications.22 In a study of observed visits, clinicians adequately explained dosages of new medications only 55% of the time and addressed adverse effects 35% of the time.23 Another study found that 19 of 51 ameliorable adverse drug events were related to patients not communicating symptoms to their clinician.24 This
theme identified communication breakdowns between the prescriber, the pharmacy and the patient. Electronic medical record (EMR) fragmentation continues to be a safety challenge when medication changes are not communicated to all three parties, resulting in inappropriate refilling of discontinued medication or a prior dose. Actionable takeaways from this medication safety theme include the following: standardising expectations for clinicians to explain dosages of new prescriptions and potential adverse effects, particularly for high risk medication such as opioids, hypoglycemics and anticoagulants; becoming aware of and identifying common over-the-counter drug interactions; making sure discontinued drugs are communicated to pharmacies and patients, ideally through EMR integration between prescribers and pharmacies. Additionally, more education around medication regimens prior to procedures if patients are fasting, as well as patient teaching on drug allergies, are needed.

Our final theme highlights how patients living with disabilities are vulnerable to the external environment, including healthcare, home and community settings. Hospitals and clinics should adopt universal compliance with the Americans with Disabilities Act which is not currently in place in the majority of ambulatory clinics, and increases risk of injury. Home healthcare access and safety assessments should be routine to minimise fall risks and ensure appropriate access to appropriate adaptive equipment in the home. A notable subset of the disability-related events occurred during a lapse in attention or absence of a caregiver. A key takeaway from these events is the importance of appropriate access to consistent home caregiver support for people living with disabilities.

Although our approach enables a more comprehensive assessment of patient and caregiver factors than prior studies, current adverse event reports are filtered by the perspective of the healthcare worker making the entry. There are likely far more numerous and complex patient and caregiver contributing factors which were not named in the CHPSO data. Given patients and caregivers are the primary agents in ambulatory care, their perspective and insights could be captured in future adverse events to better depict a holistic picture of contributing factors to adverse events. For PSO-collected data, providers and staff entering in adverse event reports could be encouraged to elicit patient factors as part of their entry. PSO data capture forms could also include a structured field to include patient barriers. Additionally, patients and caregivers could collect or report adverse events they observe themselves; this has been successful in the inpatient setting as well as thorough pharmacovigilance assessments. Finally, individual clinics and hospitals can include patients and caregivers in adverse event review and root cause analysis, as has been done in prior research studies and is underway in a UK-based, National Institute for Health Research (NIHR)-funded initiative. Without enhanced reporting that addresses patient and caregiver perspectives, proposed solutions may not appropriately address the factors contributing to ambulatory adverse events.

Limitations
Strengths of our analysis include the following: large random sample, robust mixed quantitative and qualitative approach, and involvement of a multidisciplinary stakeholder team to discuss and review events. The events in the CHPSO database are representative of what is submitted to PSOs in the USA. However, event reports do not represent the ‘true universe’ of ambulatory adverse events. There is selection bias in what gets observed, what gets reported and how much data get submitted from a member site to a PSO. However, these are currently the most comprehensive samples of ambulatory patient safety data in healthcare, and as such, provide important formative data to inform interventions. Specific limitations of the CHPSO database include a lack of details about participating healthcare sites, such as geographic location, payer type or clinician demographics. We did not create an audit trail to document the extent of congruence between the individual coders; instead we used discussion to arrive at consensus on our themes.

CONCLUSION
Ambulatory patient safety reports should consider the patient and caregiver perspective. Based on the limited perspectives, we can glean from healthcare staff-entered reports, actionable steps include the following: addressing patient priorities when giving safety precautions, fulfilling best practices in communication and education when starting or changing medications, and improving accessibility and accommodations for patients with disabilities. Involvement of patients and caregivers in both event reporting and report review will become a priority for patient safety in ambulatory care.

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Contributors AES conceived the project aims and scope, obtained ethics board approval, led data transfer, formed study team and Stakeholder Advisory Research Council, developed data abstraction strategy, conducted data coding, led analysis

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and interpretation and wrote the majority of the article. BH conducted dual coding of half of included events, participated in qualitative interpretation of themes and edited the article. The Stakeholder Advisory Council provided guidance on data abstraction form, qualitative interpretation of results, informed content of the article and provided edits to the article. JBD and JY participated in data coding and edited the article. WJB conducted statistical analysis to identify co-occurring events. US participated in overall conception of project scope and aims, interpretation of results and edited the article.

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REFERENCES
1 Buettov S, Elwyn G. Patient safety and patient error. Lancet 2007;369:156–61.
2 Gurwitz JH, Field TS, Harrold LR, et al. Incidence and preventability of adverse drug events among older persons in the ambulatory setting. JAMA 2003;289:1107.
3 Shekelle PG, Smith PZL. Patient safety in ambulatory settings. Technical brief no. 27. (Prepared by the Southern California evidence-based practice center under contract No. 290-2015-00010-I). AHRQ publication no 16(17)-EHC033-ER. (17 16). Rockville, MD: Agency for Healthcare Research and Quality, 2016.
4 Kohn LT, Corrigan J, Donaldson MS. To err is human: building a safer health system. Washington, D.C: National Academy Press, 2000: xxi, 287.
5 Lang S, Garrido MV, Heintze C. Patients’ views of adverse events in primary and ambulatory care: a systematic review to assess methods and the content of what patients consider to be adverse events. BMC Fam Pract 2016;17:1-9.
6 O’Hara JK, Lawton RJ. At a crossroads? key challenges and future opportunities for patient involvement in patient safety. BMJ Qual Saf 2016:25:565–8.
7 Bates DW, Singh H. Two decades since to err is human: an assessment of progress and emerging priorities in patient safety. Health Aff 2018;37:1736–43.
8 ECRI. ECRI Institute: diagnostic tests, medication pose biggest risks to patients in ambulatory care, 2020. Available: https://dxr4v99712pyz.cloudfront.net/p/images1/ecri-trusted-voice-healthcare.jpg
9 CHPSO. 2019 CHPSO annual report, 2020. Available: https://www.chpso.org/pod/2019-chpso-annual-report
10 Sharma AE, Yang J, Del Rosario JB, et al. What safety events are reported for ambulatory care? analysis of incidence reports from a patient safety organization. Jt Comm J Qual Patient Saf 2020;46:309–20. doi:10.1097/01.jqcs.0000680169.68474.2d
11 Forman J, Damschroder L. Qualitative content analysis. In: Jacoby L A, Sminoff L, eds. Empirical methods for bioethics: a primer. Bingley: Emerald Group Publishing Limited, 2007: 11–39–62.
12 Hahsler M, Grün B, Hornik K. arules - a computational environment for mining association rules and frequent item sets. J Stat Softw 2005;14:1–25.
13 Thomas DR. A general inductive approach for analyzing qualitative evaluation data. Am J Eval 2006;27:237–46.
14 Lyson HC, Sharma AE, Cherian R, et al. A qualitative analysis of outpatient education use in community settings: observed safety vulnerabilities and recommendations for improved patient safety. J Patient Saf 2021;17:e335–42.
15 Reason J. Human error: models and management. BMJ 2000;320:768–70.
16 Cooper J, Edwards A, Williams H, et al. Nature of blame in patient safety incident reports: mixed methods analysis of a national database. Ann Fam Med 2017;15:455–61.
17 Collins ME, Block SD, Arnold RM, et al. On the prospects for a blame-free medical culture. Soc Sci Med 2005;68:1287–90.
18 Busch IM, Saxena A, Wu AW. Putting the patient in patient safety investigations: barriers and strategies for involvement. J Patient Saf 2021;17:358–62.
19 George J. Medical morbidity and mortality conferences: past, present and future. Postgrad Med J 2017;93:148–52.
20 Wu AW, Huang I-C, Stokes S, et al. Disclosing medical errors to patients: it’s not what you say, it’s what they hear. J Gen Intern Med 2009;24:1012.
21 health.gov. National action plan for ade prevention, 2020. Available: http://health.gov/our-work/health-care-quality/adverse-drug-events/national-ade-action-plan
22 Mira JJ, Orozco-Beltrán D, Pérez-Jover V, et al. Physician patient communication failure facilitates medication errors in older polymedicated patients with multiple comorbidities. Fam Pract 2013;30:56–63.
23 Tarn DM, Herina J, Paterniti DA, et al. Physician communication when prescribing new medications. Arch Intern Med 2006;166:1855–62.
24 Gandhi TK, Weingart SN, Borus J, et al. Adverse drug events in ambulatory care. N Engl J Med 2003;348:1556–64.
25 Urban R, Paloumpi E, Rana N, et al. Communicating medication changes to community pharmacy post-discharge: the good, the bad, and the improvements. Int J Clin Pharm 2013;35:813–20.
26 Jaremsiornprikul N, Chaipichit N, Chumworathay P, et al. Management for improving patients’ knowledge and understanding about drug allergy. Pharm Pract 2015;13:513.
27 Welage N, Liu KPY. Wheelchair accessibility of public buildings: a review of the literature. Disabil Rehabil Assist Technol 2011;6:1–9.
28 Weissman JS, Schneider EC, Weingart SN, et al. Comparing patient-reported Hospital adverse events with medical record review: do patients know something that hospitals do not? Ann Intern Med 2008;149:100–8.
29 Haas JS, Iyer A, Orav EJ, et al. Participation in an ambulatory e-pharmacovigilance system. Pharmacoepidemiol Drug Saf 2010;19:961–9.
30 Inácio P, Cavaco A, Airaksinen M. The value of patient reporting to the pharmacovigilance system: a systematic review. Br J Clin Pharmacol 2017;83:227–46.
31 Zimmerman TM, Amer C, Including patients in root cause and system failure analysis: legal and psychological implications. J Healthc Risk Manag 2007;27:27–34.
32 Gertler SA, Coralic Z, López A, et al. Root cause analysis of ambulatory adverse drug events that present to the emergency department. J Patient Saf 2016;12:119–24.
33 Bradford Institute for Health Research/University of Leeds. PFI-SII project research summary, 2019. Available: https://yhpstrc.org/wp-content/uploads/2019/10/PFI-SII-Summary-Research-Plan-1st-October-2019.pdf