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A realist analysis of hospital patient safety in Wales: applied learning for alternative contexts from a multisite case study

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Disclaimer: This report contains transcripts of interviews conducted in the course of the research, or similar, and contains language that may offend some readers.

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Plain English summary

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Plain English summary

The safety of patients in British hospitals is a major social problem because 1 in 10 is harmed during his or her care. UK policy responses focus on new improvement programmes to implement multiple 'evidence-based' interventions, such as checklists of what should be done during surgery. Such interventions are tested on a small scale (e.g. in one operating theatre) before being rolled out more widely.

Although it is known that the success of the programmes varies among hospitals, it is not known why. This is the first study to examine how the 'contextual' features of a hospital (e.g. its size) and its environment (e.g. political values) combine to influence patient safety programmes. Our study had two main parts. First, we developed a new model for analysing the implementation of improvement programmes that directs attention to multiple layers of context. Second, we used our model to conduct seven in-depth case studies of the 1000 Lives+ patient safety programme across Wales. The main source of our information was 160 interviews, supplemented by our archive of nearly 2000 documents, and the observation of practice.

Our findings show how, for specified programme interventions (e.g. surgical checklists), hospital and environmental features combine to derive varied outcomes seen as either more or less successful by stakeholders such as public, professionals, researchers and policy-makers. Our model and findings provide a valuable basis from which stakeholders can (a) better understand existing improvement programmes and (b) design more effective ones in the future.

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