Service user perspectives on patient safety in the ambulance service

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BACKGROUND
The contribution of service users to healthcare research is vital to ensure that evidence based policy and practice is relevant to their needs. Their experiences and knowledge are an essential complement to contributions from clinicians, health professionals and researchers.
The aim of this research was to explore service user perceptions of ambulance service care and patient safety, focusing on transition decisions.

METHODS
Focus groups were conducted with service users in three Ambulance Service Trust regions.
FG 1 (n=7); FG 2 (n=8); FG 3 (n=8)
The discussions enabled participants to share their respective perceptions, experiences and concerns in relation to transition decision by front-line ambulance service staff.
Discussions were audio-recorded, transcribed and thematically analysed.

SERVICE USER CONCERNS
Call handling – communication and triage
Skills of call handlers in obtaining critical information for appropriate triage decisions. Risk was considered to be greater where callers have communication difficulties/impairment.
Support for shared NHS access to patient information for initial triage and on scene decisions

Involvement in decisions
Patient/carer involvement in decisions made at-scene considered important but different levels of understanding in relation to their rights were apparent. Perceived tension between safety and dignity (e.g. end of life care).
Variability in awareness of new ambulance service roles and alternatives to ED conveyance

Balancing demand and resources
Concern over the impact of increasing demand for ambulance service care on staff and patient s. The ambulance service was perceived “filling the gap” where there are difficulties in accessing urgent care or limited awareness of alternatives.
Expanding patient education in self-management of chronic conditions was desirable to reduce demand and patient risk.

Access to care
The impact of delays at A&E was a concern in relation to individual patients at A&E and others waiting for an ambulance.
Non-conveyance was viewed as an acceptable option, and where appropriate, alternative care is assured. Limited awareness of paramedic skills and alternatives to ED conveyance contributed to concerns over non-conveyance

Risk aversion
Risk aversion amongst the public and health professionals (e.g. GPs) was perceived as a potential contributor to the increased demand for emergency care.

Geographical location
Longer journey times in rural areas considered a risk but voluntary first responders were felt to be working well in reaching patients quickly. Concerns over increased centralisation and longer journeys to specialist centres.
Cross boundary working an issue for patients bordering two Trusts where the nearest station is in a neighbouring Trust.

Vulnerable patients
Concern over potential delays for some patients (e.g. wheelchair users, bariatric patients) due to limited availability of vehicles.
Specific patient populations were considered particularly vulnerable at care transitions (e.g. communication difficulties, mental health/capacity problems, requiring end of life care).

CONCLUSIONS
Despite the relatively small sample, the findings provide useful service user perspectives on care transitions and safety concerns in the prehospital emergency care setting.
As highlighted by a number of participants, it is important that such views can be represented through public/patient involvement in decision making at organisational and service commissioning level: “…I think it is this sort of thing that ambulance services need because we are talking as people, either service users or people outside of the service and that is what the ambulance services need”.

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Service user participants
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If they’re signposted somewhere else other than hospital, who makes sure that happens? Who will follow that up? 25 years ago it would have been the GP, wouldn’t it. Who does make sure that the patient actually receives the appropriate treatment?

I suppose at the end of the day ambulance service personnel are only human and sometimes you make a personal judgment, don’t you as to whether somebody is safe isn’t safe or whatever...And also, you’ve got to think about the service as a whole. So you’ve got to consider not just the risk to that patient but also the risk to the other patient.

It doesn’t matter if the first responder isn’t a specialist or qualified in that area as long as they can give assistance. And then ... The qualified response turns up afterwards.”

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