Adverse events in healthcare services: A qualitative study of municipalities' and supervisory authorities' investigations and follow-up.

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Why?

- Patient harm resulting from adverse events remains a persistent challenge, despite many years of effort.

- Most of the available knowledge comes from the specialist health services, while less is known about primary health care.

- The responsibility of the healthcare organizations

- The responsibility of the supervisory authorities

What?

The overall aim of this study is

"to explore how the framing and understanding of adverse events in primary care informs the way the events are followed up on and which improvement measures are chosen by the municipalities.

The study aims to develop new knowledge about how leaders and healthcare professionals in municipalities develop and implement action plans in the follow-up of adverse events.

Furthermore, it aims to explore how the involvement of the supervisory authorities influences the learning and improvement processes following adverse events, with the purpose of contributing to developing "the supervisory toolkit"."

The following research questions (RQ) will guide the study:

- RQ1: How do municipalities investigate and understand adverse events?

- RQ2: How are investigations of adverse events followed up by the municipalities?

- RQ3: How do the supervisory authorities influence learning and improvement processes in the municipalities following adverse events?

How?

Study	Data collection	Level/selection	Analysis
1	Documents: adverse events reported to the supervisory authorities, reports and other written material prepared by the municipality regarding the investigation and assessment of the incident. Individual interviews (total: 30-50).	Frontline leaders and employes at the Municipalities.	Document analysis: directed content analysis. Qualitative content analysis (interviews)
2 & 3	Documents: reports and other written material prepared by the municipality regarding the follow-up of the incident. Individual interviews patients/next-of-kin (total: 5-15) Focus group interviews (total: 10).	Patients/next-of-kin. Frontline leaders and employes at the Municipalities. Supervisory team at the County Governor.	Document analysis: directed content analysis Qualitative content analysis (interviews)

Theoretical Perspectives

- **Patient safety and accident theory**

- **Learning**

Dear colleagues and partners:

Do you have specific advice or proven best practices to improve the learning process after adverse events?

Please feel free to contact me:

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