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Final year medical students' reflections on perceived significant events during an integrated primary care block

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ABSTRACT

Background: Adverse events are considered a universal challenge and a burden in healthcare. For that reason, significant event analysis is a necessary tool in primary healthcare, particularly in South Africa where many people access healthcare services from the public health system.

Aim: The study aimed to explore medical students' reflections of perceived significant events experienced during integrated primary care block placement in primary healthcare (PHC) settings.

Methods: Using a qualitative descriptive design with purposeful sampling and maximum variation, structured reflection reports were retrieved from logbooks of final year medical students. During the 2014 academic year students were allocated to 18 primary healthcare settings across three provinces. Of the 228 logbooks that were submitted at the end of seven rotations, only 207 contained a recording of a significant event and met the criteria to be included in the study. Conventional content analysis was used to record the relevant facets of secondary data related to the research question using MAXQDA software version 2020.4.

Results: Following an iterative research process, 128 records of significant events analysed revealed five themes. The type of significant events that were prevalent in PHC settings, included inadequate patient management, patient diagnosis errors, as well as medication and prescription errors. Likely causes of the perceived significant events were cited as human factors and health system challenges. Consequences revealed both students and patients' health-related concerns. An interesting consequence observed was that significant events created learning opportunities for students. The response to recorded significant events was facility specific and ranged from no action taken, to a more positive and structured response such as debriefing sessions during M&M meetings, training, daily equipment and resource checks, display of posters, protocol adherence and close monitoring of patients. Improvement strategies included staff and patient education, as well as addressing human resources and infrastructural challenges.

Conclusion: Significant event analysis is a critical quality improvement reflective learning tool. Using logbooks, it was possible to explore medical students' experiences of significant events as a strategic way towards addressing quality and safe practices in PHC settings. Participants proposed integrated capacity-building to address potential causes of the perceived significant events.

Keywords: significant events, significant event analysis, reflection, medical students, primary healthcare