

Patient Engagement and Safety

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Background

The traditional paternalistic model of medicine, in which patients have little voice in their care, has slowly but surely been evolving toward a model in which patients and clinicians work in a partnership toward the common goal of improved health. As articulated in the seminal Institute of Medicine report [Crossing the Quality Chasm](#), such [patient-centered care](#) should be "respectful of and responsive to individual patient preferences, needs, and values and ensure that patient values guide all clinical decisions."

While many patient safety interventions have used traditional models of effecting change, such as changing provider behavior, encouraging interprofessional collaboration, and enhancing the [culture of safety](#), the patient's role in safety has not been overlooked. The Joint Commission mandated that health care organizations "encourage patients' active involvement in their own care as a patient safety strategy" as a [National Patient Safety Goal](#) in 2007, catalyzing research into how patients may partner with providers to prevent errors.

Patients' Role in Preventing Errors

Efforts to engage patients in safety efforts have focused on three areas: enlisting patients in detecting adverse events, empowering patients to ensure safe care, and emphasizing patient involvement as a means of improving the culture of safety.

Enlisting patients in detecting adverse events

Hospitalized patients are routinely surveyed about their satisfaction with the care they received, and recent research has examined whether patient surveys may be used as an error detection mechanism. Studies in the [inpatient](#) setting have found that patients often report errors that were not detected through traditional mechanisms such as chart review; indeed, patient-reported errors formed the basis of landmark studies of

[adverse events after hospital discharge](#). Concerns have been raised, however, that patient complaints may center on poor [service quality](#) rather than on clinical adverse events.

Empowering patients to ensure safe care

Patients are also being encouraged to take an active role in their own safety. The Agency for Healthcare Research and Quality's [Questions Are the Answer](#) program and [20 Tips to Help Prevent Medical Errors](#) fact sheet, as well as The Joint Commission's [Speak Up](#) initiative, are examples of programs that educate patients about safety hazards and provide specific questions that patients (and their caregivers) can ask regarding safety. Although patients have voiced [concerns](#) about engaging in behaviors that may seem confrontational (for example, asking their clinician if she washed her hands), some preliminary [studies](#) have found that active engagement of patients can improve adherence to safety practices. The widespread availability of electronic medical records is also being used as an opportunity to engage patients in safety efforts. Early studies have leveraged information technology to incorporate patients in [medication reconciliation](#) and early identification of [outpatient adverse drug events](#).

Emphasizing patient involvement as a means of improving the culture of safety

Finally, hospitals are increasingly recognizing the crucial role of patients' perspectives in establishing a [culture of safety](#). Many institutions (such as the [Dana-Farber Cancer Institute](#)) have prioritized engaging patient representatives in the design and nurturing of safety efforts, and emphasize transparency in reporting errors and care problems. The active engagement of patients in safety efforts has extended to allowing [patients and families](#) to summon [rapid response teams](#), rather than waiting for clinicians to respond. Studies in the [intensive care unit](#) and [inpatient pediatric wards](#) have shown that interventions that explicitly include patient and family engagement can improve safety culture and may reduce adverse event rates.

Although patient engagement is a promising strategy for error reduction, there is reason for caution on several grounds. From a systems engineering viewpoint, the level of patient and family participation will always be difficult to predict, leading some to [argue](#) that a robust safety program should not depend on such engagement. Furthermore, patients and caregivers already shoulder a significant emotional burden for ensuring safety while hospitalized. An important [study](#) found that a surprising number of patients and family members feel guilty after a medical error, and another [study](#) found that most parents of hospitalized children felt personally responsible for ensuring their child's safety in the hospital. Engaging patients in error prevention therefore risks simply [shifting the responsibility](#) for safety from providers and institutions to patients themselves.

Current Context

Patient engagement in safety efforts is a strong priority of influential regulatory and governmental organizations. The Agency for Healthcare Research and Quality and the World Health Organization sponsor a variety of programs centered around patient education and encouraging patient perspectives to improve safety culture. In addition to its prioritization of patient engagement through the National Patient Safety Goal, The Joint Commission also provides educational resources for patients around safety

measures in pediatric, hospital, and [surgical](#) settings.