

## PEER REVIEW HISTORY

BMJ Open publishes all reviews undertaken for accepted manuscripts. Reviewers are asked to complete a checklist review form (<http://bmjopen.bmj.com/site/about/resources/checklist.pdf>) and are provided with free text boxes to elaborate on their assessment. These free text comments are reproduced below.

### ARTICLE DETAILS

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| <b>TITLE (PROVISIONAL)</b> | Adverse event reviews in healthcare: What matters to patients and their family? A qualitative study exploring the perspective of patients and family. |
| <b>AUTHORS</b>             | McQueen, Jean M; Gibson, Kyle; Manson, Moira; Francis, Morag  |

### VERSION 1 – REVIEW

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| <b>REVIEWER</b>        | Smith-Merry, Jennifer<br>The University of Sydney, Faculty of Health Sciences |
| <b>REVIEW RETURNED</b> | 09-Feb-2022   |

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| <b>GENERAL COMMENTS</b> | This is a field that I'm really familiar with and when I was reading over the paper I was continually agreeing with what the participants had said and the comments that the authors had made about their findings. I think it was this that is the main critique of the paper - I'm not sure how this paper builds on previous work to present new and interesting findings. They definitely confirm what has been found before and that shows that the research was sound (and indeed the methodology was very sound and results presented clearly). However I am not sure this is enough. The paper, I feel (the editors may disagree), should be offering some new perspective. Results from studies going back 15 years (e.g. the ledema et al study you cite) have said these same things over and over. If that is your point then make it clear, but if there is more that you want to say to build on this existing literature then highlight that more. Either way you need to bring in more of the big international studies on patient experience of adverse events, and perhaps patient centred care in general, to build on. The discussion was very much lacking in an engagement with this existing literature. Other than that it was a well written and concise paper which I enjoyed reading. Typo in methods line 41, p 7, sentence ends with 'by'. |
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| <b>REVIEWER</b>        | Kara, Areeba<br>Indiana University School of Medicine |
| <b>REVIEW RETURNED</b> | 09-Mar-2022   |

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| <b>GENERAL COMMENTS</b> | It is good to see the progression of thought in healthcare- from whether patients and families should be involved in the adverse event review process - to how it should be done best. The authors interviewed patients and/or their families who were involved in a serious adverse event and asked them about their experience. A few clarifications:<br>1- Were there any incentives offered for participation? This is not clear in the manuscript currently. |
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|  | <p>2- In the Demographics table please clarify that this is the employment status of the patient involved in the event</p> <p>3- What definition of 'serious' event was used in the recruitment process?</p> <p>4- Readers may appreciate a table summarizing recommendations for best practices around the involvement of patients and families in these reviews.</p> <p>My gratitude to the authors and to the patients and families willing to share their experience to advance knowledge.</p> |
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## VERSION 1 – AUTHOR RESPONSE

### Reviewer 1

| Comment   | Response  |
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| Not sure how this paper builds on previous work to present new and interesting findings. Results from studies going back 15 years have said these things if that is your point then make it clear                   | Thank-you this is our point and why we feel it is important to publish. Despite all the research the participants we spoke to are still struggling to get their voices heard and redress the power balance in the review process. We have added comment to that effect in the discussion and what our paper does add now (in response to reviewer 2 comments) is clear recommendations on how to enact this in practice. This is something that is not clearly articulated in previous publications on this topic. See the addition of table 3.   |
| Need to bring in more of the big international studies on patient experience of adverse events, and perhaps patient centred care in general. The discussion was lacking in engagement with the existing literature. | <p>Thank you we have reviewed more of the existing literature on this topic and have added in references and discussion points to reflect the international literature and wider person centred movement.</p> <p>Case, J. , Walton, M. , Harrison, R. , Manias, E. , Iedema, R. &amp; Smith-Merry, J. (2021). What Drives Patients' Complaints About Adverse Events in Their Hospital Care? A Data Linkage Study of Australian Adults 45 Years and Older. <i>Journal of Patient Safety</i>, 17 (8), e1622-e1632. doi: 10.1097/PTS.0000000000000813.</p> <p>Harrison R, Birks Y, Bosanquet K, Iedema R. Enacting open disclosure in the UK National Health Service: A qualitative exploration. <i>J Eval Clin Pract</i>. 2017;23:713–718.<br/> <a href="https://doi.org/10.1111/jep.12702">https://doi.org/10.1111/jep.12702</a></p> |

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|  | <a href="#">We have drawn on person centred care more widely and cited the what matters to you movement which was published in 2012 and spread to over 49 countries important reference added to support the links made in the discussion</a> Barry MJ Edgman-Levitan S (2012) Shared decision making – The pinnical of patient-centred care N Engl J Med 2012; 366:780-781 DOI: 10.1056/NEJMp1109283 |
| Typo in methods line 41, p 7, sentence ends with 'by'. | This is now corrected thank you   |

Reviewer 2

| Comment  | Response  |
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| Were there any incentives offered for participation? This is not clear in the manuscript currently.  | There were no incentives offered for participation and have made this clear in the manuscript. See Participant selection and participation  |
| In the Demographics table please clarify that this is the employment status of the patient involved in the event                               | Added narrative to explain this in table 1<br>*employment status of participants  |
| What definition of 'serious' event was used in the recruitment process?  | Definition added as follows An adverse event is defined as harm to a patient because of health care and includes medication errors, missed diagnosis, system or medical device failure, an unexpected event causing harm requiring additional treatment, or resulting in death or psychological trauma. |
| Readers may appreciate a table summarizing recommendations for best practices around the involvement of patients and families in these reviews | Thank you this is a really helpful comment and we have added table 3 to clearly articulate our recommendations  |

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[https://www.who.int/patientsafety/en/brochure\\_final.pdf](https://www.who.int/patientsafety/en/brochure_final.pdf)

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