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Thinking thematically: top tips for completing a thematic review

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What is a thematic review?

A thematic review can identify patterns in data to help answer questions, show links or identify issues. Thematic reviews typically use qualitative (eg open text survey responses, field sketches, incident reports and information sourced through conversations and interviews) rather than quantitative data to identify safety themes and issues. Thematic reviews can sometimes use a combination of qualitative data with quantitative data. Quantitative data may come from closed survey responses or audit, for example.

These top tips support health and social care staff to carry out thematic reviews, but organisations may take different approaches, depending on the purpose and scope of their review.

When should I use a thematic review?

Thematic reviews can be used for multiple purposes, for example:

- developing or revising your organisation's safety improvement plan
- aggregating information from many diverse sources of safety intelligence/ datasets
- gathering insight about gaps/safety issues across a pathway or as part of an overarching safety theme to direct further analysis
- aggregating findings from multiple incident responses to identify interlinked contributory factors to inform/direct improvement efforts

- presenting summary data to show the impact of ongoing safety improvement work.

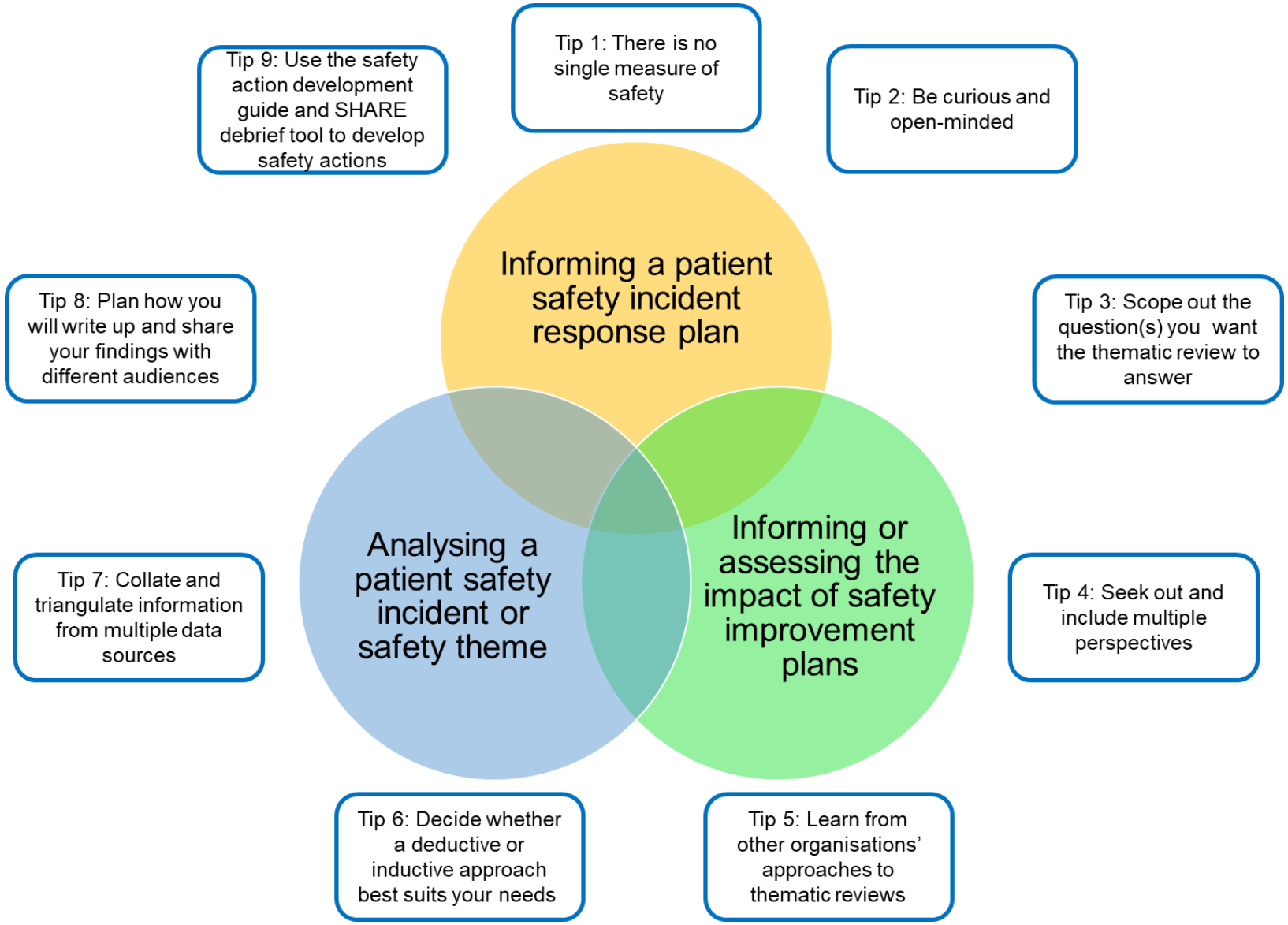
A framework for thematic reviews to support learning responses

Figure 1 outlines three examples of how thematic reviews can be used within PSIRF to support learning and improvement:

1. Collating data from different datasets to inform the development of an organisation's patient safety incident response plan.
2. Analysing a patient safety incident or safety theme to identify issues and themes using qualitative and, sometimes, quantitative data.
3. Triangulating and synthesising data to inform or assess the impact of patient safety improvement plans.

Appendix 1 gives examples of the different approaches to thematic review.

Figure 1: Three thematic review approaches to support learning and improvement



Top tips

We have split the tips into those that apply to all four types of thematic review, and those that are specific to types 2, 3 and 4.

Tip 1: There is no single measure of safety

Safety insights come in both qualitative and quantitative forms. Remember that what you hear, what you see and what you perceive are as important as hard data. Explore and triangulate insights from different types of data.

Tip 2: Be curious and open-minded

Be willing to explore.

Look for evidence that challenges your hypothesis. Making assumptions too early can bias your findings. Be wary of drawing conclusions too soon.

Be open to what the data is telling you.

Tip 3: Scope out the question(s) you want the thematic review to answer

Think about what you are trying to find out from the data. For example, what factors contributed to this incident or safety theme? How might we use thematic analysis to generate an incident profile? What types of qualitative and quantitative data would enable us to evidence the impact of ongoing improvement work?

By starting with a clear set of questions, you will focus your thematic review and stop your analysis from drifting off-course.

Tip 4: Seek out and include multiple perspectives

Getting perspectives and opinions from others will make your findings less subjective and bring innovative ideas you might not have thought of.

Tip 5: Learn from other organisations' approaches to thematic reviews

There are many ways to carry out thematic reviews: Several good useful templates are available, including:

- Healthcare Safety Investigation Branch (HSIB) National learning report: A thematic analysis of HSIB's first 22 national investigations.
- Aronson J (1995). A pragmatic view of thematic analysis. The Qualitative Report 2(1): 1–3.

Additional content is available on the NHS Patient Safety FutureNHS platform.

Remember to share approaches to thematic analysis across your professional networks. Reach out to colleagues in other trusts and seek their advice on using thematic reviews as part of PSIRF.

Tip 6: Decide whether a deductive or inductive approach best suits your needs

Deductive thematic analysis involves analysing the data according to pre-determined themes and categories. It is driven by your theoretical or analytical interest. It may provide a more detailed analysis of some aspects of the data than **inductive thematic analysis** that generates themes and categories directly from the data, but overall tends to produce a poorer description of the data[1].

In the context of analysing patient safety data sources, a deductive thematic analysis might include a review of specific aspects/standards of care. Or it could be framed using a systems-based framework like Systems Engineering Initiative for Patient Safety (SEIPS) or a tool like the Human Factors Analysis and Classification System (HFACS), with data sorted into the different dimensions of these frameworks.

Inductive thematic analysis involves coding qualitative data into clusters of similar entities or conceptual categories to identify consistent patterns and themes. An inductive approach involves deriving meaning and creating themes from data with fewer preconceptions than in a deductive thematic review.

See Appendix 2 for examples of deductive and inductive thematic analysis.

Tip 7: Collate and triangulate information from multiple data sources

Be open to sourcing and triangulating various sources of safety information.

There are many types of data (both qualitative and quantitative) you can use, and no fixed rules about what types you should use. The appendix illustrates the types of safety information you may want to analyse, eg incidents reported to your local incident reporting system, complaints, conversations with staff and patients, Friends and Family test data and patient safety incident investigation reports.

You may also want to analyse sources such as clinical notes or the findings of other learning response approaches like after action reviews, structured judgement reviews, horizon scanning or multidisciplinary team reviews of a case or safety theme.

[1] Braun, V., & Clarke, V. (2006) Using thematic analysis in psychology. Qualitative research in psychology, 3, 77-101

Be open to different information sources and collect more if you need to.

Tip 8: Plan how you will write up and share your findings with different audiences
When writing up your findings, use anonymised vignettes or examples. This will bring your findings to life.

Remember you need to summarise the themes and issues you have identified from the analysis.

Tip 9: Use the safety action development guide and SHARE debrief tool to develop safety actions

The safety action development guide and SHARE debrief tool support health and social care teams to collaboratively develop and prioritise safety actions.

Appendix 1: Examples of three approaches to thematic review

Type	Example
Informing a patient safety incident response plan	Director of quality and safety B commissioned one of his team to carry out a thematic review to inform the development of the organisation's patient safety incident response plan. Several types of data were used in the thematic review including: • the analysis of free text in a sample of incident reports, complaints letters and patient surveys • interviews with a cross-section of staff working in clinical and non-clinical roles • focus groups with patients, carers and their families, • minutes from the Quality and Safety Committee and Medication Safety Committee and Risk Governance meetings over the last two years. • walk throughs and observations of patient care. The thematic review identified four safety themes for the organisation to focus on: medication errors, patient deterioration, safety in the operating theatre and IT system safety. It also provided evidence that robust improvement work was underway for patient falls, pressure ulcers and healthcare acquired infections, which informed the decision not to investigate these categories of incidents. Going forward, resources would instead be directed to the spread and sustainability of the improvement work.
Analysing a patient safety incident or safety theme	**Example 1:** Learning response lead C led a thematic review of risks to patients attending the emergency department (ED), and to the safety of staff caring for them. The aim was to identify issues and themes, and to inform where further analysis or alignment with other improvement efforts for this group of patients was needed (including self-harm and violence and aggression against staff and other patients). Learning response lead C collated the following information for the thematic review: • the findings from six serious incident investigation reports completed over the last two years relating to self-harm and/or violence and aggression to staff and patients • six formal complaint letters received by patients with a mental health diagnosis • observations carried out in the ED, including in the areas where mental health patients are cared for

	• incident report data (including analysis of the free text on incident reporting forms) • interviews with staff working in the ED, psychiatric liaison service, neighbouring mental health trusts, and police and social care services colleagues • performance data for the psychiatric liaison service (including time taken to carry out mental health risk assessments for patients presenting at the ED). Data from the various datasets was themed and collated. The following system gaps were identified: • a culture of using the hospital security team to observe mental health patients in the ED because the trust did not employ any registered mental health nurses (RMNs) and agency RMNs were difficult to book at short notice • no dedicated area in the ED to treat patients presenting with psychosis • lack of access to computers and workspaces for the psychiatric liaison service in the ED, meaning they had to wait to access a computer to complete risk assessment documentation. **Example 2:** Learning response lead D led a thematic review of a series of cases where patients and staff caught COVID-19. Issues pertaining to each case were identified. The findings were then synthesised to identify common themes. The thematic review identified the following: • rapid COVID-19 testing (one-hour turnaround) was not in place at the time of the outbreak, meaning the COVID-19 positive status of the index (ie first case) was not known until she had been an inpatient on the ward for 48 hours • there were insufficient workstations on wheels (WoWs) so although the organisation's COVID-19 infection control procedures required wards to assign a WoW to a single bay, this was not workable in practice. Movement of WoWs around the ward may have been a source of infection for staff. The ward had one staff room, and this was small and poorly ventilated. Although staggered lunch and rest breaks had been implemented, in practice it was not always possible for staff to take their breaks at the times they had been allocated. This meant several staff usually ate their lunch together in the staff room, thus increasing the risk of transmission.
Informing or assessing the impact of patient safety improvement plans	Learning response lead E carried out a thematic review to assess the impact of organisation Y's 'Reducing falls with harm improvement plan'. Information from staff focus groups and falls prevention diaries (describing each clinical area's implementation of the plan) was triangulated with falls audit

	data, incident reports and summaries from monthly matron walk rounds. The various data sources were themed using an inductive analysis approach. The thematic review enabled organisation Y to better understand the barriers to reducing harm from patient falls that ward staff had encountered in the first year of implementing the plan: these related to the design of the falls risk assessment pro forma and releasing staff to attend educational sessions due to pressures on wards. Its findings prompted organisation Y to work to improve the design and usability of the falls risk assessment pro forma. Falls harm reduction drop-in clinics were introduced across the organisation to improve the reach and spread of the improvement plan.

Appendix 2: Examples of deductive and inductive thematic reviews

Example of a deductive thematic review

Learning response lead G carried out a thematic review of controlled drug safety in organisation X after a cluster of incident reports indicated that controlled the drug procedure was not being followed. He chose to use a deductive thematic approach, framing the analysis using the SEIPS. Data from incident reports, investigations, stock monitoring systems, controlled drug audits, staff interviews, observations in clinical areas, national reports and guidance relating to controlled drug safety was collated.

The six dimensions of the SEIPS model were used to classify systems gaps/issues that impacted on controlled drug safety in organisation X. The following issues were identified:

- **Technology and tools:** Organisation X's recent move to an electronic healthcare record means the software used to track controlled drug stock and usage is no longer compatible and cannot be used.
- **External influences:** the regulatory context around controlled drugs involves several agencies and professional bodies, meaning it is challenging to keep up to date with changes to national guidance and policy.
- **Organisation:** elements of organisation X's controlled drug procedure are unworkable in clinical areas that have multiple controlled drug cupboards, eg intensive care units. This procedure requires the nurse in charge to hold the keys to the controlled drug cupboard throughout a shift. The ICU has a controlled drugs cupboard in each of the eight patient bays because the multidisciplinary team often needs to access controlled drugs quickly and having one set of keys held by the nurse in charge would (i) delay access to and administration of controlled drugs and (ii) mean the nurse in charge is frequently interrupted during a shift, including during safety critical procedures like handovers.
- **Person:** safety migrations were identified in the incident and investigation reports, and through observations – some ward nurses are not strictly monitoring access to the controlled drug cupboard.
- **Work environment:** some clinical environments make it more challenging to keep track of controlled drug use and supply; for example, the acute medical unit and ICU use higher volumes of controlled drugs and have multiple controlled drug cupboards.
- **Task:** ward staff are often distracted and interrupted when selecting and checking controlled drugs before administering them to patients. These interruptions are now seen as normal.

The patient safety and quality improvement teams considered the information from the thematic review at their regular patient safety improvement planning meeting. They agreed that the outdated software should be reviewed by the trust's IT/digital team as part of the ongoing digital transformation, and then considered which of the other issues posed the greatest risk and opportunity for improvement. Supplementary information (survey data from clinical staff, audit and observation data) was sought and reviewed. This indicated that the areas where controlled drug safety posed the greatest risk were the acute medical unit and ICU. Further work was needed to explore different systems for management of access to the controlled drugs cupboards in these

areas, and to better understand what factors were contributing to the deviations from the controlled drug procedure.

It was agreed that task issues relating to the administration of medication and normalisation of interruptions should be analysed further using swarm huddles and included in the medication safety improvement programme.

Example of an inductive thematic review

Learning response lead H carried out an inductive thematic review of the safety of residents in care homes. Her aim was to identify factors that contributed to a range of acquired infections that were common in care homes A and B. She reviewed incident data and triangulated this with information from complaints, staff interviews and family and resident feedback.

She read the 'How to start to thematically analyse qualitative data: A step by step guide and top tips' (see above) to get some insights into how best to carry out an inductive thematic analysis. In Microsoft Excel she colour-coded the data into 'chunks' and then grouped related codes to identify themes. Iteratively, she regrouped and reorganised the data, reading it and reviewing the datasets multiple times. At every iteration, she challenged her thinking and analysis by asking herself whether the data clearly evidenced and supported each theme. Revisiting the evidence in this way helped her identify a set of final themes across the different data sources. She then organised these into a theme table and a thematic map.

Theme	Code(s)	Example text
Education and training	E-learning	There was an over-reliance on e-learning to educate care home staff on best practice for infection prevention and control. Staff interviews: "I don't find e-learning that helpful. When I completed the infection prevention and control e-learning module I skipped through it and completed the test at the end of the module – a lot of my colleagues did the same." "I cannot access e-learning at home and there is no protected time to complete the e-learning on our shifts." "The only training I have had in the last year was our mandatory e-learning." Complaint letter: "E-learning helps management tick a box to show we are compliant with our mandatory training; it does not educate staff on best practice with infection prevention and control." Incident data: The use of e-learning as the main source of infection prevention and control education may be partly responsible for poor handwashing practices among the team.

Theme	Code(s)	Example text
Handwashing	Infection control supplies	Family member feedback: “The staff who care for my mother do their best but sometimes the soap and alcohol gel dispensers are empty so they cannot always wash their hands before turning or feeding her.” Staff interviews: “The sinks in rooms 3 and 4 were leaking, so we were told not to use them until they were fixed. This took 3 weeks to organise.” “We repeatedly raise concerns about the soap and alcohol gel dispensers running out and delays with the supply of sterile wipes, but things never improve.” Incident data: Incident report 1: Delay in fixing a leaking sink impacted on the ability of staff to wash their hands. Incident report 2: Alcohol gel dispensers at the entrance to several resident rooms were empty and could not be replenished because the supply had been used up.
Care home staff workload	Time pressure and multi-tasking	Staff interviews: “Sometimes you forget to wash your hands because you are rushing from one resident to another.” “It’s like there are a million things to do in the next hour you forget to do things you should because of the pressure to get things done.” Letter of complaint: “My father’s care in your home is compromised because the care team are rushing around from one resident to another; they are clearly struggling. Other relatives and I have previously raised concerns about this with the care home manager.” Resident feedback: “The staff try their best, but I don’t like to ask for help because I can see how busy and pressured they are”.