Knowledge & Library Services

NHS Somerset NHS Foundation Trust

CURRENT AWARENESS BULLETIN

PATIENT SAFETY

MAY 2023

This is your monthly Current Awareness Bulletin produced by Knowledge & Library Services at Somerset NHS Foundation Trust.

It is intended to provide you with a range of the most up-to-date resources, including recently published guidelines and research articles, news and policy items.

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We hope you find it helpful and please do let us know if you need any further information or assistance.

Thank you.

BREAKING NEWS

Human Factors: Using the SEIPS framework for patient safety and investigations (pslhub, 23 May 2023)
SEIPS 2.0 is the most widely used model in human factors in healthcare. This one-day masterclass will look at the model itself and how it can be applied to healthcare departments. It will look at real world examples as well as the literature.

Bristol Patient Safety Conference 2023 (Bristol Patient Safety, 17 May)
For everyone with an interest in QI and patient safety. An independent national conference - accredited to award 6 RCP CPD points. Plenary speakers include: Baroness Helena Kennedy KC, Shaun Lintern, Tim Spector, Dr Jenny Vaughan OBE.

Safety for All: Human Factors and Patient Safety webinar (pslhub, 03 May 2023)
Human Factors principles aim to understand the 'fit' between an employee, their equipment and the surrounding environment, which can include learning styles, behaviours and values, leadership, teamwork, the design of equipment and processes, communication and organisational culture. In healthcare Human Factors can improve both performance and well-being while improving staff and patient safety. Human Factors has the most significant impact when applied systematically throughout the organisation. The Safety For All campaign is hosting a webinar on the topic of Human Factors and patient safety where attendees will have the opportunity to hear from two experts in the field.

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COMMUNICATION

- **Duties of candour: being open and honest with patients (BJN, 06 April 2023)**
  Good patient communication strategies are an essential prerequisite for developing an effective NHS patient safety culture and the NHS needs to improve on its efforts. We have seen repeatedly in reports of investigations into NHS patient safety crises that major failings have been identified. If we take some of the most recent patient safety reports, we see tragic failings in communication to patients and between health professionals, such as in East Kent.

- **Co-production resource toolkit (NHS England, 03 April 2023)**
  In 2018, the Care Quality Commission published a report into 'Quality improvement in hospital trusts'. It highlighted that active and meaningful consultation with and involvement from patients would be a key factor in QI in future; this is 'co-production'. The toolkit published here introduces, discusses and outlines resources to be used in the process of co-production.

- **Accessible patient information: a key element of informed consent (by Julie Smith)(pslhub, 20 March 2023)**
  Consent to treatment such as operations and diagnostic procedures can only be truly informed if the patient understands the risks, benefits and alternatives. They also need to have considered what will happen if they choose not to have any treatment at all. A failure to obtain informed consent is not only unlawful, but can contribute to lasting physical and psychological harm. In this blog, hub Topic Leader Julie Smith looks at the different areas to consider when creating written information that is genuinely useful to the patient. Julie's advice also helps readers understand how they can provide information that is medico-legally sound.

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LEADERSHIP

- **Should we really send more money to the front line? (Nuffield Trust, 11 May 2023)**
  Join this new online event series to engage in challenging debate and get a second opinion on whether some of the fundamental assumptions in modern health policy really bear scrutiny.

- **Progress for some but the average patient waits longer and longer (Nuffield Trust, 13 April 2023)**
  Jessica Morris responds to the latest monthly NHS performance statistics.

- **Interactive Patient Safety and Quality Improvement capstone during transition-to-residency program: virtual and in-person focused workshop for EPA 13 (BMC Medical Education, 12 April 2023)**
  Identifying systems failures and contributing to a safety culture is the Association of American Colleges (AAMC's) thirteenth Entrustable Professional Activity (EPA). While most curricula teach Patient Safety (PS) and Quality Improvement (QI) principles, student participation in live QI/PS activities remains limited. This workshop enabled late Clerkship phase students to apply these Health Systems Science (HSS) principles to real adverse patient event cases through team-based simulation.

- **Cuts to social care reform funding are a betrayal (Nuffield Trust, 04 April 2023)**
  Nuffield Trust Deputy Director of Policy Natasha Curry responds to a new announcement on social care.

- **NHS Key Statistics: England, March 2023 (House of Commons Library, 13 March 2023)**
  This briefing gives a summary of statistics for the NHS in England in the following broad areas:
  - Demand for emergency and planned hospital care, and measures of NHS capacity, pressures, and backlogs
  - Waiting times and other performance measures for acute care
  - Staff numbers: doctors, nurses, GPs, and other staff groups, plus Vacancies

- **Digital health laws and regulations: emerging trends in the global regulation of digital health 2023. (Global Legal Group; 2023)**
  Technological advancements in the health care industry can create opportunity to transform and improve health care access and delivery, reduce costs and advance public health as a whole. Chapter discusses key legal constructs that digital health companies and investors must consider, in the US, the UK and the EU.

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SAFETY CULTURE

- **Daily Insight: 'Toxicity, cronyism and bullying'(HSJ, 29 March 2023)**
  The first report into safety and culture at University Hospitals Birmingham has dropped. As many expected, medics who contributed to the first of three reviews – this one by Professor Mike Bewick on patient safety – were scathing in their descriptions of poor culture and bullying. The former NHS England medical director's team heard repeated reports of "long-standing bullying" and "toxic" work environments, while senior medics at UHB's tertiary site Queen Elizabeth Hospital in particular levelling serious accusations at leaders of "cronyism" around appointing senior leaders and in HR processes.

- **Improving patient safety culture: A practical toolkit for health and care workers(pslhub, 28 March 2023)**
  Safety culture has been a key and recurring theme in reports where there has been poor care. Its ubiquity has hampered our understanding of what it is, and it has become apparent that it means different things to different people, and at different hierarchical levels. Without a common understanding of what we perceive safety culture to be, it is difficult to understand how to create a positive shift. The toolkit from NHS England and the AHSN Network is currently a draft version (March 2023). It aims to give teams an understanding of how to craft, create and nurture a positive safety culture and provide a theoretical underpinning to how to shift the culture. It covers safety culture, teamwork and communication, just and restorative culture, psychological safety, promoting diversity inclusive behaviour, and civility.

- **Still not safe to speak up: NHS Staff Survey Results 2022(pslhub, 23 March 2023)**
  In this blog, Patient Safety Learning looks in detail at the results of the NHS Staff Survey 2022, focusing on responses relating to reporting, speaking up and acting on safety concerns.

- **Asking the fundamental questions(BJN, 23 March)**
  It is important that we all try to find time to reflect on what we do, to see where we are going and where we have been. In a busy NHS this is difficult, but it is nevertheless important to try – all professionals need to do this as change happens and we must properly prepare for it. Several recent publications discussed here have caused us to reflect on some fundamental issues in patient safety and clinical negligence.

- **A Novel Approach to the Room of Errors (ROE): A Three-Dimensional Virtual Tour Activity to Spotlight Patient Safety Threats. (Cureus, 14 March 2023)**
  Live simulation-based activities are effective tools in teaching situational awareness to improve patient safety training in healthcare settings. The coronavirus disease 2019 (COVID-19) pandemic forced the discontinuation of these in-person sessions. We describe our solution to this challenge: an online interactive activity titled the "Virtual Room of Errors." The aim of this activity is to create an accessible and feasible method of educating healthcare providers about situational awareness in the hospital. The virtual ROE is an accessible, feasible, and cost-effective method of educating healthcare workers on situational awareness of preventable hazards. Furthermore, the activity is a sustainable way to reach a larger number of learners from multiple disciplines, even as in-person activities resume.

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WELLBEING

- **Public satisfaction with the NHS and social care in 2022: Results from the British Social Attitudes survey (Nuffield Trust, 29 March 2023)**
  The Nuffield Trust and The King's Fund have joined forces again to publish the gold-standard measure of public attitudes and opinions towards the NHS and social care, as surveyed by NatCen during 2022. Public satisfaction with the health service has slumped to its lowest level ever recorded in the 40-year history of the British Social Attitudes survey.

- **Public satisfaction with the NHS and social care in 2022: Results from the British Social Attitudes survey (King's Fund, 29 March 2023)**
  The National Centre for Social Research's (NatCen's) British Social Attitudes (BSA) survey has been conducted annually since 1983. Each year the survey asks people what it's like to live in

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Britain and what they think about how Britain is run, including measuring levels of public satisfaction with the health and care services. The most recent survey was carried out between 7 September and 30 October 2022 and asked a nationally representative sample (across England, Scotland and Wales) of 3,362 people about their satisfaction with the National Health Service (NHS) and social care services overall, and 1,187 people about their satisfaction with specific NHS services, as well as their views on NHS funding.

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TEAMWORK

- **Introducing a structured daily multidisciplinary board round to safely enhance surgical ward patient flow in the bed shortage era: a quality improvement research report (BMJ Open Quality, 27 March 2023)**
  Hospital bed shortage is a worldwide concern. We report quality improvement after we introduced a structured daily multidisciplinary board round framework (SAFER Surgery R2G) adapted from the 'SAFER patient flow bundle' and the 'Red to Green days' approaches to enhance flow. The SAFER Surgery R2G framework has increased patient flow in the context of an enhanced multidisciplinary approach, requiring senior staff commitment to remain sustainable.

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WORK ENVIRONMENT

- **Human factors in operating theatres (pslhub, 09 May 2023)**
  Understanding human factors will allow surgical teams to enhance performance, culture and organisation of operating theatres. This one-day masterclass will concentrate on human factors within the operating room. This is aimed at all theatre staff. It will look at why things go wrong and how to implement change to prevent it from happening again or mitigate the risks. This Masterclass will focus on systems to improve patient safety as well as looking at never events and how to learn from them using a human factors approach.

- **The gender divide in reasons for economic inactivity (Nuffield Trust,12 April 2023)**
  There has been a recent increase in the numbers of people who say they are economically inactive (that is, not in work for various reasons), with rises in long-term sickness a particular challenge for health services. As John Appleby shows, however, there were some notable differences between men and women in the reasons they gave for being inactive.

- **Barriers and facilitators to improving patient safety learning systems: a systematic review of qualitative studies and meta-synthesis (BMJ Open Quality, 03 April 2023)**
  The implementation and continuous improvement of patient safety learning systems (PSLS) is a principal strategy for mitigating preventable harm to patients. Although substantial efforts have sought to improve these systems, there is a need to more comprehensively understand critical success factors. This study aims to summarise the barriers and facilitators perceived by hospital staff and physicians to influence the reporting, analysis, learning and feedback within PSLS in hospitals.

- **Qualitative study on experience of healthcare staff who have undergone a hybrid root cause analysis training programme (BMJ Open Quality, 01 April 2023)**
  Root cause analysis (RCA) is a structured investigation methodology aimed at identifying systems factors to prevent recurrence of incidents. To enhance staff's knowledge and skills, a hybrid RCA training course was conducted in February 2021. Overseas instructors conducted training online and local participants attended the training together physically with onsite facilitator support. This study aimed at understanding the experiences of trainees who have undergone the training, evaluated its effectiveness and identified opportunities to enhance RCA training quality in the future.

- **Types of diagnostic errors reported by paediatric emergency providers in a global paediatric emergency care research network (BMJ Open Quality, 29 March 2023)**
  Diagnostic errors, reframed as missed opportunities for improving diagnosis (MOIDs), are poorly understood in the paediatric emergency department (ED) setting. We investigated the clinical experience, harm and contributing factors related to MOIDs reported by physicians working in paediatric EDs.

- **'Shaming' level of misery caused by UK social care uncovered by major survey (The Guardian, 26 March 2023)**
  Two-thirds of people who have used social care report bad experiences, as problems of low pay and poor training grow.

- **The Preventable Deaths Tracker: a presentation by Dr Georgia Richards (pslhub, 23 March 2023)**
  In this audio recording from the 2023 Chief Coroner's Conference at Central Hall Westminster, we hear Dr Georgia Richards present on the work of the Preventable Deaths Tracker. Dr Richards explains why this work was so necessary, how it can be used to reduce future avoidable deaths and why we need to ensure that the learning and data shared in coroner reports has impact on the ground.

- **National campaign aims to reduce patient harm from infiltration and extravasation(pslhub, 14 March 2023)**
  Infiltration is when fluid or intravenous drugs administered to a patient (which are given to patients into a vein through a cannula or other device) inadvertently leak into the tissue surrounding a vein by mistake. Extravasation is when infiltration occurs but the drugs involved are called vesicants which can damage the tissue and cause serious harm to the patient. The National Infusion and Vascular Access Society (NIVAS) are leading a campaign to improve awareness of infiltration and extravasation and reduce avoidable harm.

- **ONE SIZE DOESN'T FIT ALL: reimagining medicines information for patients (KSSAHSN, March 2023)**
  A State of the Nation Report reviewing findings from patient and healthcare professional engagement.

- **REIMAGINING MEDICINES INFORMATION FOR PATIENTS (KSSAHSN, March 2023)**
  The new report investigates the current medicines product information paradigm and whether it can be enhanced to more positively influence both patient experience of and adherence with prescription medication. The report also explores if an opportunity exists to improve how this information might be provided in the future using digital solutions with the aim of increasing its value to patients and healthcare professionals (HCPs).

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QUALITY IMPROVEMENT

- QI Evidence Update (April 2023)

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