

CURRENT AWARENESS BULLETIN

PATIENT SAFETY

Oct 2024

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BREAKING NEWS & EVENTS

HTN, [Two new reviews launched to examine patient safety, quality and governance within the health system](#), 21 October

The UK government has shared plans for two reviews exploring patient safety within the health system, examining firstly the roles and remits within six organisations overseen by the Department of Health and Social Care with a “significant” impact on patient safety, with a view to making recommendations on whether a different approach could offer improvements; and secondly focusing on quality and governance.

HSJ, [Safety alert over 25 serious incidents linked to common drug](#), 24 Sept

- National patient safety alert issued over risk of oxytocin overdose
- Follows NHSE review of 25 incidents linked to inappropriate use of drug
- Concerns previously raised by Ockenden and East Kent reports

Special Topic: Maternity & Paediatrics

Guardian, [NHS maternity staff to receive mandatory training to improve patient safety](#), 7 Oct

Obstetricians, midwives and obstetric anaesthetists will take part in pilots after damning report by health regulator

HSJ, [Patient Safety Watch: Further evidence maternity safety is going in the wrong direction](#) 11 Oct

Latest MBRRACE-UK report highlights urgent need to improve care for mothers

Government announces pilot to reduce brain injury in childbirth

New chief named for watchdog

NHSE director issues warning about beds ahead of winter

New toolkit launched for repeat prescriptions

Staff 'rebuked' for raising safety concerns about cancer treatment
Positive:
PSIRF in Practice course wins *HSJ* poster prize
Can you help improve escalation of suspected fetal deterioration?
Baby Lifeline launches Maternity Unit Marvels Awards 2025
Website launched to share learning from inquests and inquiries
HSJ Patient Safety Congress sessions available for those who missed it

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SEPSIS

Kullberg, R. F. J., Haak, B. W., Chanderraj, R., Prescott, H. C., Dickson, R. P., & Wiersinga, W. J. (2024). [Empirical antibiotic therapy for sepsis: Save the anaerobic microbiota](#). *The Lancet Respiratory Medicine*,

Antibiotics are fundamental in sepsis management; however, the optimal empirical treatment remains debated. Despite anaerobes rarely being the causative pathogen of sepsis, antibiotics targeting them are frequently used, which might lead to unintended consequences. Multiple studies have shown that depletion of commensal anaerobic gut microbes by anti-anaerobic antibiotics influences systemic immunity and is associated with increased mortality in patients with sepsis. However, this knowledge has not yet been translated into clinical practice. When considering empirical coverage of anaerobic pathogens in sepsis, most physicians advocate for a better-safe-than-sorry approach. In this Viewpoint, we argue that anti-anaerobic antibiotics could often result in being sorry rather than safe. We provide an overview of the limited necessity of anaerobic coverage and the potential detrimental effects of anaerobic depletion in sepsis. We aim to raise anaerobic awareness to reduce the unnecessary use of anti-anaerobic antibiotics in empirical sepsis treatment and improve patient outcomes.

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FALLS PREVENTION

Albornos-Munoz, L., Blanco-Blanco, J., Cidoncha-Moreno, M. A., Abad-Corpa, E., Rivera-Alvarez, A., Lopez-Pisa, R. M., . . . Moreno-Casbas, M. T. (2024). [Efficacy of the otago-exercise-programme to reduce falls in community-dwelling adults aged 65-80 when delivered as group or individual training: Non-inferiority-clinical-trial](#). *BMC Nursing*, 23(1), 705.

BACKGROUND: The Otago Exercise Programme is an effective intervention for falls prevention. However, there is limited evidence in relation to studies that compare efficacy for falls prevention when delivered Otago Exercise Programme in a group or individual format in a primary care context. **OBJECTIVE:** To compare the Otago Exercise Programme delivered as a group vs. individual format for community dwelling older adults, over a one year period. The hypothesis was that neither format would be inferior to the other.

Dewi, A., Meisari, W. A., Almanfaluthi, M. L., Ambarwati, D., Dewi, R., Handini, D. R. P., . . . Dewi, T. S. (2024). [Health workers' perception on fall risk prevention: A photovoice method](#). *Journal of Patient Experience*, 11, 23743735241273674.

Health workers' awareness can affect hospital fall prevention success. Enhancing awareness can be achieved by exploring their perspectives on the phenomenon. This study aims to explore health workers' perceptions regarding fall risk prevention in hospitals.

Hwang, W., Oh, K., Kim, M. G., Kim, W. B., Lee, H. S., Chung, S. G., . . . Kim, K. (2024). [Lack of fall prevention education in patients experiencing fall-related hip fracture: A qualitative study](#). *Geriatric Orthopaedic Surgery & Rehabilitation*, 15, 21514593241280926.

Introduction: We aimed to describe patient awareness regarding fall prevention and education, perceived causes of falls, and changes in attitude after experiencing a fall through interviews with older Korean patients who experienced falls with resultant hip fractures. **Materials and**

Jung, W., Lim, S., Wi, D., Ustach, A., & Thompson, H. J. (2024). [Person-focused interventions for fall risk assessment, fall prevention and fall injury prevention in long-term care facilities: A scoping review](#). *Injury Prevention*,

OBJECTIVE: Falls are a significant concern in long-term care facilities (LTCFs) as fall-related injuries can result in functional impairment, disability and death. Older adults living in LTCFs are at greater risk for falls than those in the community. Using scoping review methodology, we aimed to synthesise evidence examining intervention effects of person-focused interventions for risk assessment and prevention in LTCFs in order to identify evidence-based practices in LTCFs.

Katiri, R., Holman, J. A., Magner, S., O'Cahey, C., & Byrne, C. P. (2024). [Application of the world guidelines for falls prevention and management's risk stratification algorithm to patients on a frailty intervention pathway and the potential utility of sensory impairment information](#). *BMC*

Geriatrics, 24(1), 824. **BACKGROUND:** The 2022 world guidelines for falls prevention and management suggest measuring sensory function including dizziness, vision, and hearing. These variables are not included in the falls risk stratification algorithm. This study sought to investigate the utility of the guidelines and potential avenues for improvement. This study applied the falls risk stratification recommendations and reviewed the individual sensory impairment risk factor variables predictive of falls and falls risk grouping in those assessed by a frailty intervention team (FIT) based in an emergency department (ED).

Linnerud, S., Bjerck, M., Olsen, N. R., Taraldsen, K., Brovold, T., & Kvael, L. A. H. (2024). [Managers' perspectives on their role in implementing fall prevention interventions: A qualitative interview study in norwegian homecare services](#). *Frontiers in Health Services*, 4, 1456028.

Introduction: The implementation of fall prevention interventions in homecare services is crucial for reducing falls among older adults and effective leadership could determine success. Norwegian

homecare services provide home nursing, rehabilitation, and practical assistance, to residents living in private homes or assisted living facilities. This study aims to explore how managers in Norwegian homecare services experience implementation of fall prevention interventions and how they perceive their roles

Namoos, A., Thomson, N., Bradley, S., Rudderman, A., & Aboutanos, M. (2024). [Memory loss and missteps: Investigating fall risks in alzheimer's and dementia patients.](#) *Advances in Geriatric Medicine and Research*, 6(3)

Background: Degenerative diseases such as Alzheimer's disease and dementia are significant health concerns among older adults in the United States, contributing substantially to the high incidence of falls in this population. This study aims to investigate the incidence and prevalence of falls among older adults diagnosed with Alzheimer's disease and dementia and explore the association between these conditions and the occurrence of traumatic brain injuries (TBIs).

Rice, L. A., Yehya, M., Yi, J., Koziel, S., & Peterson, E. W. (2024). [Translation, extension, and evaluation of usability, usefulness, and safety of a fall prevention and management program for people living with spinal cord injury and multiple sclerosis who use wheelchairs or scooters full time.](#) *Frontiers in Rehabilitation Sciences*, 5, 1406938.

Background: Falls are prevalent among people living with Multiple Sclerosis (PwMS) and Spinal Cord Injury (PwSCI) who use wheelchairs or scooters (WC/S) full time, however, there is a scarcity of evidence-based fall prevention and management programs. **Objective:** To describe the systematic translation of an in-person fall prevention and management program (Individualized Reduction Of FaLLs - iROLL) for PwMS to an online platform, extending its scope to include PwSCI, and to evaluate the preliminary useability, usefulness, and safety of the intervention.

Zanotto, A., Zanotto, T., Alexander, N. B., & Sosnoff, J. J. (2024). [Views and experiences of older people taking part in a safe-falling training program: Lessons learned from the Falling safely training \(FAST\) trial.](#) *BMC Geriatrics*, 24(1), 818.

BACKGROUND: While falls are the leading cause of accidental injury among older people, the current fall prevention strategies have not resulted in a remarkable reduction in fall rates. An alternative novel approach, teaching older adults how to fall safely to prevent injury, has been recently implemented in the Falling Safely Training (FAST) trial. The current study aimed to explore the views and perceptions of older people about their participation in the safe-falling training program.

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SAFETY CULTURE

Beteta Fernandez, D., Pereda Mas, A., Perez Canovas, C., Navarro Egea, A. P., Pardo Rios, M., & Alcaraz-Martinez, J. (2024). [Culture of safety in an adult and paediatric emergency department before and after the COVID-19 pandemic.](#) *Emergency Medicine Journal*,

BACKGROUND: The WHO recognises patient safety as a serious public health problem. The COVID-19 pandemic affected adult EDs (AEDs) and paediatric EDs (PEDs) differently. We compared the culture of safety in the adult AED and PED before and after the COVID-19 pandemic.

Murray, J. S., Baghdadi, A., Dannenberg, W., Crews, P., & Walsh, N. D. (2024). [The role of high reliability organization foundational practices in building a culture of safety.](#) *Federal Practitioner*, 41(7), 214–221.

Background: High reliability organizations are designed to operate under complex conditions for extended periods by strengthening systems that help serious adverse events for patients. The US

Department of Veterans Affairs formally began its enterprise-wide journey to high reliability in 2019. Four foundational practices were identified to advance a culture of safety across all Veterans Health Administration facilities. This article describes these practices, summarizes supporting evidence from the literature, and illustrates strong practices for improving safety.

Tingle, J. (2024). [The current state of patient safety in the NHS: The darzi report](#). *British Journal of Nursing*, 33(18), 900–901.

John Tingle, Associate Professor, Birmingham Law School, University of Birmingham, discusses the recent Darzi report on the NHS in England.

Upadhyay, S., & Chien, L. (2024). [The influence of hospital physician integration on culture of patient safety](#). *Journal of Patient Safety*,

BACKGROUND: Medical errors are responsible for a large number of deaths every year in the United States. Hospitals use various strategies including leadership, staffing, and structural changes to deal with this concerning issue. Hospital physician integration is a structural strategy to possibly improve patient safety. Using the conceptual lens of Donabedian's Structure Process Outcome model, this study aims to investigate how hospital physician integration affects organizational, management, and communication attributes of patient safety culture.

Vibe, A., Rasmussen, S. H., Rasmussen, N. O. P., Ostergaard, D., & Dieckmann, P. (2024). [The predictors of patient safety culture in hospital setting: A systematic review](#). *Journal of Patient Safety*,

INTRODUCTION: Patient safety (PS) is a global public health concern. It is estimated that 10% of patients experience preventable harm while hospitalized. Patient safety culture (PSC) has been recognized as essential to improving PS, drawing inspiration from other high-risk industries. In PS research, however, PSC poses conceptual challenges, with inconsistent terminology, a lack of definitions, and limited use of substantiating theory. Despite these challenges, PSC remains widely used in PS research and practice, as it is seen as a potential gateway to understanding sociotechnical complex aspects of the healthcare system and improving safe patient treatment and care. **OBJECTIVES:** This review explores the concept of PSC in a hospital setting. How PSC is used as an outcome, thus exploring the theoretical position underpinning PSC, which predictors impact PSC, and how these predictors are related to PSC.

Molitch-Hou, E., Best, T. J., Green, E., Nguyen, K. T., LaShore, G., & Cerasale, M. T. (2024). [Handoffs and equity: Impact of a patient distribution model on handoffs for black patients](#). *Journal of Racial & Ethnic Health Disparities*,

BACKGROUND: Hospital medicine patient distribution models (PDM) assign patients to inpatient services on hospital admission. Models balance tradeoffs including patient handoffs, physician wellness, subspecialty care, and other factors to ensure optimal outcomes; however, equity is rarely considered. Handoffs during inpatient care can result in medical error and worse patient outcomes. This study evaluates the impact of a PDM that prioritizes use of specialty care services and an overflow service (OS) during high census on racial inequities in handoff frequency.

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NEAR MISSES, MEDICATION ERRORS, REPORTING SYSTEMS

Kavanagh, R., & Ward, M. E. (2024). [What is known about near miss events in the operating room? A systematic review of studies of mixed methods design.](#) *Irish Journal of Medical Science*,

BACKGROUND: A near miss event (NME) in healthcare is an event that did not happen but would have caused serious harm if it did. The operating room (OR) is prone to risk and incidents, with estimates that 50% of all hospital adverse events occur in the OR, yet reporting of NME is uncommon in the OR. **OBJECTIVE:** To carry out a systematic review of studies with mixed methods to establish what is known about NME reporting in the OR.

Li, B., Yue, L., Peng, H., Chen, X., Sohaib, M., Peng, B., . . . Zou, W. (2024). [Analysis of the incidence and factors influencing medication administration errors among nurses: A retrospective study.](#) *Journal of Clinical Nursing*,

AIMS: To explore the incidence and factors influencing medication administration errors (MAEs) among nurses. **BACKGROUND:** Medication administration is a global concern for patient safety. Few studies have assessed the incidence of MAEs or explored factors that considered the interplay between behaviour, the individual and the environment.

Lam-Antoniades, M., Petten, N., & Nyhof-Young, J. (2024). [Simple tool for teaching patient safety through incident analysis.](#) *Canadian Family Physician*, 70(10), 662–665.

Motsi, L. (2024). [Electronic health records model to improve the quality of patients' healthcare.](#) *Health SA Gesondheid*, 29, 2414. **Background:** Electronic health records (EHR) has been acknowledged for bringing down healthcare costs and enhancing hospital service standards. **Aim:** The aim of this study was to develop an EHR model to lower patient treatment costs and enhance healthcare quality in South African public healthcare.

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SIMULATION, AI, TECHNOLOGY, GAMIFICATION

Challener, D. W., Fida, M., Martin, P., Rivera, C. G., Virk, A., & Walker, L. W. (2024). [Machine learning for adverse event prediction in outpatient parenteral antimicrobial therapy: A scoping review.](#) *Journal of Antimicrobial Chemotherapy*,

OBJECTIVE: This study aimed to conduct a scoping review of machine learning (ML) techniques in outpatient parenteral antimicrobial therapy (OPAT) for predicting adverse outcomes and to evaluate their validation, implementation and potential barriers to adoption.

Hassan, E. A., & El-Ashry, A. M. (2024). [Leading with AI in critical care nursing: Challenges, opportunities, and the human factor.](#) *BMC Nursing*, 23(1), 752.

INTRODUCTION: The integration of artificial intelligence (AI) in intensive care units (ICUs) presents both opportunities and challenges for critical care nurses. This study delves into the human factor, exploring how nurses with leadership roles perceive the impact of AI on their professional practice. **OBJECTIVE:** To investigate how nurses perceive the impact of AI on their professional identity, ethical considerations surrounding its use, and the shared meanings they attribute to trust, collaboration, and communication when working with AI systems

Radaelli, D., Di Maria, S., Jakovski, Z., Alempijevic, D., Al-Habash, I., Concato, M., . . . D'Errico, S. (2024). [Advancing patient safety: The future of artificial intelligence in mitigating healthcare-associated infections: A systematic review.](#) *Healthcare*, 12(19)

BACKGROUND: Healthcare-associated infections are infections that patients acquire during hospitalization or while receiving healthcare in other facilities. They represent the most frequent negative outcome in healthcare, can be entirely prevented, and pose a burden in terms of financial and human costs. With the development of new AI and ML algorithms, hospitals could develop new and automated surveillance and prevention models for HAIs, leading to improved patient safety. The aim of this review is to systematically retrieve, collect, and summarize all available information on the application and impact of AI in HAI surveillance and/or prevention.

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QUALITY IMPROVEMENT & HUMAN FACTORS

Fermin, L., Lobaugh, L., Parr, K. G., & Currie, M. (2024). [The role of human factors engineering in patient safety.](#) *Current Opinion in Anaesthesiology*,

PURPOSE OF REVIEW: To explore the collaboration between human factors (HFs) experts and clinicians in order to improve perioperative patient safety. **RECENT FINDINGS:** Recent recommendations to integrate human factors into anesthesia in the United Kingdom emphasizes the value of applying disciplines outside of medicine to optimize the patient experience.

Sam, J., Baid, M., & Dhandapani, K. (2024). [Human factors: Do they impact surgical performance?.](#) *Cureus*, 16(9), e69507.

INTRODUCTION: Human factors in surgery relate to the environmental, organisational, and human factors that can impact performance in the operating theatre. This study assesses whether various factors such as music, counting backwards, and attempting to do simultaneous tasks impact surgical time and performance.

Sigahi, T. F. A. C., Thatcher, A., Bolis, I., Rampasso, I. S., Saltorato, P., & Anholon, R. (2024). [Actionable insights for human factors and ergonomics to achieve the sustainable development goals: Mapping past advancements and proposing future strategic paths.](#) *Ergonomics*, 1-22

Despite significant strides in linking Human Factors and Ergonomics (HFE) and sustainability, research lacks precision in debating HFE's role, especially concerning the Sustainable Development Goals (SDGs). This paper maps concrete contributions of HFE to the SDGs, offering strategic actions for target achievement.

Sutcliffe, J., & Lomax, S. (2024). [Lessons learned from implementing a human factors programme into an NHS trust.](#) *Ergonomics*, 1-14

The interest in employing Human Factors (HF) in healthcare is increasing. There are very few papers that outline an approach to embedding the practical application of HF in healthcare and the lessons that can be learned. The SCReaM HF and Team Resource Management (TRM) programme is not only aimed at raising the awareness and understanding of the science of HF within healthcare, but also to embed its practical application to support staff improve their safety and wellbeing and that of their patients. The programme is divided into three strands: rolling training, HF Projects and HF Engineering. Each strand of the programme supports the use of HF by teaching and applying systems thinking methodology. The programme has been embedded into an NHS Trust and this paper provides a reflection on the approach used to help guide future attempts to integrate HF into an NHS trust.; plain-language-summary Interest in employing Human Factors (HF) in healthcare is increasing. The SCReaM HF and Team Resource

Management (TRM) programme has been embedded into an NHS Trust and provides a good model for how HF can be introduced and utilised within an NHS trust to improve staff and patient safety and wellbeing.

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