CURRENT AWARENESS BULLETIN

PATIENT SAFETY

Aug 2024

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BREAKING NEWS & EVENTS

House of Commons Library, Research briefing: Infected blood inquiry: recommendations for recognition, healthcare and patient safety 22 Aug 2024

HSJ, Patient Safety Watch: Don't fixate on legal costs – invest in preventing them in the first place 9 Aug 2024

NHS payouts for clinical negligence rise
Support managers 'to do the right thing' when addressing whistleblowing, says national guardian
NHS waiting lists surge for third month in a row
Ethnicity cited in baby death case
Parents brand CQC's failure to prosecute 'shameful'
Statutory medical examiners system to be brought in next month
Inquests are just 'the NHS investigating itself', says former assistant coroner
New group B strep eLearning module
Strengthening open disclosure in maternity services in the English NHS

Special Topic: Maternity & Paediatrics

Adams, M. A., Bevan, C., Booker, M., Hartley, J., Heazell, A. E., Montgomery, E., ... & Sandall, J. (2024). Strengthening open disclosure in maternity services in the English NHS: the DISCERN realist evaluation study. *Health and Social Care Delivery Research*, *12*(22), 1-159.

"The policy review identified a shift from viewing injured families as passive recipients to active contributors of post-incident learning, but a lack of actionable guidance for improving family involvement. The realist synthesis found weak evidence of the effectiveness of open disclosure interventions in the international maternity literature, but some improvements with organisation-wide

interventions. Recent evidence was predominantly from the United Kingdom. The research identified and explored five key mechanisms for open disclosure: meaningful acknowledgement of harm; involvement of those affected in reviews/investigations; support for families' own sense-making; psychological safely of skilled clinicians (doctors and midwives); and knowing that improvements to care have happened. The need for each family to make sense of the incident in their own terms is noted. The selective initiatives of some clinicians to be more open with some families is identified. The challenges of an adversarial medicolegal landscape and limited support for meeting incentivised targets is evidenced."

Escandell-Rico, F. M., & Perez-Fernandez, L. (2024). Analysis of medication errors in neonatal intensive care: A systematic review. *Medicina Intensiva,*
Medication errors, potentially causing harm and causing harm, increase significantly in newborns cared for in intensive care settings. In this sense, this work carries out a systematic review to analyze the most current evidence in relation to medication errors in neonatal intensive care, discussing the topics that refer to health technology from smart pumps, cost-effectiveness of medications, the practice of nursing professionals on the medication administration process and quality improvement models. In this way, it could be considered a useful tool to promote quality and safety in neonatal intensive care.

CONTENTS

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COMMUNICATION

Rajabi, M. (2024). The neglected role of patients in promoting patient safety. *International Journal of Community Based Nursing & Midwifery, 12*(3), 216–217.

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FALLS PREVENTION

Alvarado, N., McVey, L., Hardiker, N., Zaman, H., Dowding, D., Gardner, P., . . . Randell, R. (2024). Strategies used by nurse leaders to support the delivery of falls prevention practices in hospitals. *Nursing Older People,*
This article reflects on findings from a multi-site study on the implementation of multifactorial falls prevention practices that informed the development of actionable guidance. The discussion focuses on strategies used by nurse leaders, at different levels of seniority, that shaped practice on orthopaedic and older person wards. While falls risk assessment documentation was monitored routinely by senior leaders, in practice falls prevention often relied on risk screening and enhanced patient supervision. Findings suggest that nurses need to be empowered to lead practices that modify and mitigate individual falls risks where possible, with greater multidisciplinary and patient and carer involvement.

Jia, S., Si, Y., Guo, C., Wang, P., Li, S., Wang, J., & Wang, X. (2024). The prediction model of fall risk for the elderly based on gait analysis. *BMC Public Health, 24*(1), 2206.
INTRODUCTION: Early screening and identification are crucial for fall prevention, and developing a new method to predict fall risk in the elderly can address the current lack of objectivity in assessment tools. **METHODS**: A total of 132 elderly individuals over 80 years old residing in some nursing homes in Shanghai were selected using a convenient sampling method. Fall history information was collected, and gait data during a 10-meter walk were recorded. Logistic regression was employed to establish the prediction model, and a nomogram was used to assess the importance of the indicators. The Bootstrap method was utilized for internal validation of the model, while the verification set was used for external validation. The predictive performance of the model was evaluated using the area under the ROC curve, calibration curve, and decision curve analysis (DCA) to assess clinical benefits.

Michel, E., Zory, R., Guerin, O., Prate, F., Sacco, G., & Chorin, F. (2024). Assessing muscle quality as a key predictor to differentiate fallers from non-fallers in older adults. *European Geriatric Medicine,*
BACKGROUND: Falling is an important public health issue because of its prevalence and severe consequences. Evaluating muscle performance is important when assessing fall risk. The study aimed to identify factors [namely muscle capacity (strength, quality, and power) and spatio-temporal gait attributes] that best discriminate between fallers and non-fallers in older adults. The hypothesis is that muscle quality, defined as the ratio of muscle strength to muscle mass, is the best predictor of fall risk.

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SAFETY CULTURE

Alabdaly, A., Hinchcliff, R., Debono, D., & Hor, S. (2024). Relationship between patient safety culture and patient experience in hospital settings: A scoping review. *BMC Health Services Research, 24*(1), 906.
In this study, we aimed to explore and synthesise published literature regarding the relationships between these topics in hospital settings.

Macleod, H., & Greenfield, D. (2024). Navigating the complex terrain of patient safety: Challenges, strategies, and the importance of ongoing evaluation and knowledge sharing. *International Journal for Quality in Health Care, 36*(3)

Martin, G., Pralat, R., Waring, J., Peerally, M. F., & Lamont, T. (2024). Professionalising patient safety? findings from a mixed-methods formative evaluation of the patient safety specialist role in the english national health service. *Journal of Health Services & Research*

Policy, 13558196241268441
Objectives: While safety-dedicated professional roles are common in other high-risk industries, in health care they have tended to have a relatively narrow, technical focus. We present initial findings from a mixed-methods evaluation of a novel, senior role with responsibility for leadership of safety in English National Health Service organisations: the patient safety specialist.

Tingle, J. (2024). Is patient safety in the NHS fundamentally broken?. *British Journal of Nursing, 33*(15), 740–741.
John Tingle, Associate Professor, Birmingham Law School, University of Birmingham, discusses the state of patient safety in the NHS and several key reports.

Tsamasiotis, C., Fiard, G., Bouzat, P., Francois, P., Fond, G., Boyer, L., & Boussat, B. (2024). From reporting to improving: How root cause analysis in teams shape patient safety culture. *Risk Management & Healthcare Policy, 17*, 1847–1858.
Background: Given the increasing focus on patient safety in healthcare systems worldwide, understanding the impact of Continuous Quality Improvement Programs (QIPs) is crucial. QIPs, including Morbidity and Mortality Conferences (MMCs) and Experience Feedback Committees (EFCs), have been identified as effective strategies for enhancing patient safety culture. These programs engage healthcare professionals in the identification and analysis of adverse events to foster a culture of safety (ie the product of individual and group value, attitudes, and perceptions about quality and safety). This study aimed to determine whether patient safety culture differed regarding care provider participation in MMCs and EFCs activities.

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MEDICATION ERRORS, REPORTING SYSTEMS

Braiki, R., Douville, F., & Gagnon, M. (2024). Factors influencing novice and beginner nurses' intention to report medication errors and near misses. *Canadian Journal of Nursing Research, 8445621241263438*
Novice and beginner nurses make more medical errors than senior nurses. However, there is significant underreporting of medication errors and near misses among novice and beginner nurses. **OBJECTIVE**: To identify the factors that influence the intention of novice and beginner nurses to report medication errors and near misses**.**

Chance, E. A., Florence, D., & Sardi Abdoul, I. (2024). The effectiveness of checklists and error reporting systems in enhancing patient safety and reducing medical errors in hospital settings: A narrative review. *International Journal of Nursing Sciences, 11*(3), 387–398.
Objectives: This narrative review aimed to explore the impact of checklists and error reporting systems on hospital patient safety and medical errors.

Keum, N., Yoo, J., Hur, S., Shin, S., Dykes, P. C., Kang, M., . . . Cha, W. C. (2024). The potential for drug incompatibility and its drivers - A hospital wide retrospective descriptive study. *International Journal of Medical Informatics, 191*, 105584.
OBJECTIVE: Drug incompatibility, a significant subset of medication errors, threaten patient safety during the medication administration phase. Despite the undeniably high prevalence of drug incompatibility, it is currently poorly understood because previous studies are focused predominantly on intensive care unit (ICU) settings. To enhance patient safety, it is crucial to expand our understanding of this issue from

a comprehensive viewpoint. This study aims to investigate the prevalence and mechanism of drug incompatibility by analysing hospital-wide prescription and administration data.

Kurt, D., & Gurdogan, E. P. (2024). Do nursing students' altruism levels affect their attitudes toward medical errors? A cross-sectional study. *Nurse Education in Practice, 79*, 104083.
AIM: The aim of the current research is to determine nursing students' levels of altruism, attitudes towards medical errors and the effect of altruism on attitudes towards medical errors. **BACKGROUND**: Nursing students should be aware of medical errors and have an attitude towards correcting them. Professional values play an essential role in changing, shaping and developing attitudes in nursing students. Altruism is one of the most important determining professional values in students' professional success and development of attitudes towards different situations.

Koskiniemi, S., Syyrila, T., Hameen-Anttila, K., Mikkonen, S., Manias, E., Rafferty, A. M., . . . Harkanen, M. (2024). Patient safety incident reporting software: A cross-sectional survey of nurses and other users' perspectives. *Journal of Advanced Nursing,*
AIM: To investigate nurses' and other users' perceptions and knowledge regarding patient safety incident reporting software and incident reporting.

Salomez-Ihl, C., Chapuis, C., Bedouch, P., Albaladejo, P., & Picard, J. (2024). Can prefilled syringes help to improve patient safety?. *European Journal of Anaesthesiology, 41*(9), 711–713.

Schlesinger, M., Dhingra, I., Fain, B. A., Prentice, J. C., & Parkash, V. (2024). Adverse events and perceived abandonment: Learning from patients' accounts of medical mishaps. *BMJ Open Quality, 13*(3)
BACKGROUND: Adverse medical events affect 10% of American households annually, inducing a variety of harms and attitudinal changes. The impact of adverse events on perceived abandonment by patients and their care partners has not been methodically assessed.

Curtain, N. E., & Gugelmin-Almeida, D. (2024). Addressing human factors in the recognition and management of local anaesthetic systemic toxicity. *Journal of Perioperative Practice, 17504589241264403*
This article evaluates the impact of human factors and other aspects such as insufficient monitoring, errors in drug administration and poor adherence to safety protocols on the development and management of local anaesthetic systemic toxicity and provides practical considerations to minimise its occurrence.

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SIMULATION, TECHNOLOGY, GAMIFICATION

Farina, C. L., Moreno, J., & Schneidereith, T. (2024). Using simulation to improve communication skills. *Nursing Clinics of North America, 59*(3), 437–448.
Ineffective communication is implicated in 80% of medical errors, costing the United States approximately $12 billion annually. Teaching communication skills is a component of nursing curricula linked to improved patient outcomes. Simulation-based experience (SBE) is a strategy for healthcare professionals to learn communication skills. Providing nurses with the ability to practice nurse-nurse, nurse-physician, nurse-patient, and team communication skills in a psychologically safe learning environment provides an opportunity for skill development and meaningful self-reflection. The multiple

modalities for SBE support needed communication techniques for skill development and acquisition to improve patient outcomes.

Lopez, C. M., Laffoon, K., & Kutzin, J. M. (2024). Use of simulation for improving quality and patient safety. *Nursing Clinics of North America, 59*(3), 463–477.
Healthcare systems have been challenged to reduce errors, improve patient outcomes, and enhance the quality of care provided. Simulation can support patient safety and risk management by improving medical and nursing education, knowledge, skills, and behavior. This engaging experiential teaching method helps healthcare professionals identify and correct potential sources of error in their practice and has also improved safety and clinical outcomes.

Tsai, H., Issenberg, S. B., Chen, Y., Kang, E. Y., Chen, H., & Wu, J. (2024). Transforming medical students' speaking-up behaviors in medical errors: The impact of simulation and personalized debriefing. *Medical Teacher, 1-7*
INTRODUCTION: Sharing mental models is essential for high-performance teams, and speaking up is key for exchanging critical insights, especially during medical errors. Understanding how health providers and trainees voice their concerns is crucial for improving speaking-up behavior. This study aims to fill a gap in the literature by examining how medical students speak up when they encounter medical errors and assessing the impact of training on their speaking-up patterns.

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QUALITY IMPROVEMENT & HUMAN FACTORS

Wills, V. E. (2024). Identifying resilience: A system safety review of trauma and orthopaedic theatres. *Ergonomics, 1-11*
A prospective, qualitative study, of trauma and orthopaedic theatres was undertaken using the CARe QI handbook and the SEIPS framework, with the aim of preventing future Never Events. The study demonstrated a new approach, focussed on understanding 'work as done' to identify opportunities to improve system resilience, tested, using the Model for Improvement. Undertaken during the Covid-19 pandemic, it demonstrates that such conditions should not be a deterrent to observational studies, but requiring greater time and resource than a standard investigation, the approach may not align with current organisational or regulatory expectations. At the conclusion of this study, the mean time between Never Events in theatres had increased from 46 to 224 days, an achievement that had not previously been possible using the regulatory required, safety I, investigatory approach.

Dahmani, S., Waelli, M., & Dariel, O. (2024). Contribution of coordination theories to the determination of human factors associated with operating room perceived performance. *Anesthesia & Analgesia,*
BACKGROUND: The efficient and fluid organization of surgical interventions in an operating room (OR) and operating suite (OS) is important as these are among the most expensive units to run in medical-surgical facilities. The complexity of OS organization requires careful coordination, defined here as the directing of individuals' efforts toward achieving common and explicitly recognized goals. There is currently sparse literature on OS coordination, especially in the French context. This study aimed to respond to this gap by reporting on the coordination mechanisms associated with the perceived performance of OS across 4 facilities in an urban setting in France.

Hauptman, A. I., Mallick, R., Flathmann, C., & McNeese, N. J. (2024). Human factors considerations for the context-aware design of adaptive autonomous teammates. *Ergonomics, 1-17*
Despite the gains in performance that AI can bring to human-AI teams, they also present them with new challenges, such as the decline in human ability to respond to AI failures as the AI becomes more autonomous. This challenge is particularly dangerous in human-AI teams, where the AI holds a unique role in the team's success. Thus, it is imperative that researchers find solutions for designing AI team-mates that consider their human team-mates' needs in their adaptation logic. This study explores adaptive autonomy as a solution to overcoming these challenges. We conducted twelve contextual inquiries with professionals in two teaming contexts in order to understand how human teammate perceptions can be used to determine optimal autonomy levels for AI team-mates.

Setayesh, A., Greig, M. A., Grosse, E. H., Glock, C. H., & Neumann, W. P. (2024). A generic approach to developing human factors-quality assessment tools exemplified by the warehouse error prevention tool. *Ergonomics, 1-13*
This study proposes a generic approach for creating human factors-based assessment tools to enhance operational system quality by reducing errors. The approach was driven by experiences and lessons learned in creating the warehouse error prevention (WEP) tool and other system engineering tools. The generic approach consists of 1) identifying tool objectives, 2) identifying system failure modes, 3) specifying design-related quality risk factors for each failure mode, 4) designing the tool, 5) conducting user evaluations, and 6) validating the tool.

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