

# CURRENT AWARENESS BULLETIN

## PATIENT SAFETY

### OCTOBER 2025

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### NEW!!

From this month, we have added 3 new evidence themes which match the priority areas recently agreed at the Patient Safety Board: Nutrition and hydration, End of life/palliative care and medication, and transitions of care

Please contact [Cate.Newell@somersetft.nhs.uk](mailto:Cate.Newell@somersetft.nhs.uk) if you have any further suggestions for new themes or content.

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## NUTRITION & HYDRATION

Kuo, Y., Chen, P., & Yang, S. (2025). [Effects of a food-shaping agent on the texture and palatability of hospital-pureed meat: A comparison of subjective and instrumental assessments](#). *Foods*, 14(20)

(1) Background: This study compared subjective and objective texture classifications of hospital-provided pureed meat dishes and evaluated the impact of adding a food-shaping agent on the consistency of the food. (2) Methods: In total, 18 common pureed meat dishes (pork, chicken, and fish) from a medical center were tested. Subjective classification was conducted according to the International Dysphagia Diet Standardisation Initiative (IDDSI) level 4 criteria, and an objective texture analysis was performed using a Texture Profile Analysis (TPA), with hardness values interpreted via the Universal Design Foods (UDF) framework. (3) Results: Only six of the 18 dishes (33%) met all IDDSI level 4 tests in their original form, despite visually resembling purees. After the addition of 1% of a food-shaping agent, all samples passed IDDSI criteria, indicating enhanced textural consistency and a reduced risk of swallowing complications. TPA data confirmed that all samples, both with and without the food-shaping agent, met UDF stage 4 hardness standards ( $^3 \text{ N/m}^2$ ), ensuring appropriate structural integrity for safe swallowing. The addition of food-shaping agents significantly increased the hardness and adhesiveness ( $p < 0.001$ ), while the cohesiveness remained unchanged. (4) Conclusions: These findings highlight discrepancies between visual/subjective assessments and objective measurements and support the use of combined IDDSI- and TPA-based verification to improve dietary safety and reproducibility in dysphagia care.

Sun, T., Leonard, J., Potvin, R., Bastardi, H., & Hron, B. M. (2025). [Enteral nutrition safety practices in pediatric transplant: Perspectives of dietitians in pediatric transplant](#). *Nutrition in Clinical Practice*, <https://libkey.io/libraries/2838/10.1002/ncp.70037>

**BACKGROUND:** Our objective was to characterize enteral nutrition safety practices and education for pediatric solid organ transplant recipients and compare practices with the 2017 American Society for Parenteral and Enteral Nutrition (ASPEN) Safe Practices for Enteral Nutrition Therapy. **CONCLUSION:** Inpatient policies for formula hang-time are highly compliant with 2017 ASPEN recommendations. However, formula hang-time discharge education varied, particularly for sterile liquid formula in an open system. Standardizing enteral nutrition safety education for transplant patients is critical for minimizing infection risk within this immunocompromised population.

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## END OF LIFE/PALLIATIVE CARE

Bowers, B., Gwyn, S., Yardley, S., Hellard, S., Clarkson, J., McFadzean, I. J., . . . Carson-Stevens, A. (2025). [Learning from end-of-life injectable medication patient safety incidents in the community: A mixed-methods analysis](#). *British Journal of General Practice*,

**Background** Processes to implement injectable end-of-life symptom control medications in the community are complex and can adversely impact patient safety. Recurring patient safety incident types and their contributory factors remain under-recognised, inhibiting system-wide learning. **Conclusion** Interventions to improve injectable end-of-life symptom control care should focus on ensuring timely access to assessments and prescriptions, enhancing continuity of care, and mechanisms to ensure rapid visits to administer medication.

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## TRANSITIONS OF CARE

Gunasingha, R. M. K. D., O'Brien, M., Lutynski, M., Spear, B., Allnutt, R., Hepps, J., . . . Yu, C. (2025). [Barriers to effective perioperative handoffs: An interview-based qualitative descriptive study](#). *Journal for Healthcare Quality*,

**BACKGROUND:** Miscommunication is the leading cause of hospital medical error, most occurring during patient care handoffs. Even with successful implementation of a standardized handoff methodology, our hospital experienced continued handoff problems in the perioperative space. No studies have yet examined barriers to effective perioperative handoff communication. **CONCLUSIONS:** Our findings suggest that successful handoff communication between perioperative areas requires identification of critical administrative, communication, and personnel barriers. **IMPLICATIONS:** Hospitals can conduct similar interview-based studies to discover barriers to effective handoffs, and implement policies and procedures to improve safety in the perioperative space.

Mikkelsen, T. H., Nielsen, J. B., Storsveen, M. M., & Sondergaard, J. (2025). [Unintelligible text or codes in discharge summaries is a threat to patient safety - a nationwide survey](#). *Bjgp Open*,

**BACKGROUND:** Follow-up by the general practitioner after the patient's discharge from hospital is important for patient safety and reduces the risk of readmission to hospital. Hence it is important that discharge summaries provide effective discharge communication to general practice. **AIM:** To investigate whether general practitioners perceive incomprehensible text elements in discharge summaries as a potential threat to patient safety. **CONCLUSION:** The survey reveals that most GPs find that the discharge summaries occasionally contain incomprehensible text or codes, which raises concerns about missing critical information which may pose a threat to patient safety.

Montoya-Garrido, M., Rodriguez-Suarez, C., Mateos-Lopez, N., Santiago-Diaz, Y., & Gonzalez-de la Torre, H. (2025). [Shift-to-shift information transfer: A phenomenological study of nurses' experiences](#). *JMIR Nursing*, <https://libkey.io/libraries/2838/10.2196/81703>

**BACKGROUND:** Handovers represent a critical moment for patient safety, where the effective transfer of information between nurses is essential. In this context, digital documentation systems such as IDEAS (Identification, Diagnosis, Evolution, Activities, Support) have been implemented to standardize and enhance the quality of clinical handovers. **CONCLUSIONS:** While the IDEAS system represents an improvement over previous handover methods, its effectiveness remains constrained by technical, organizational, and cultural barriers. Optimizing the system requires clinically oriented redesigns, alongside training strategies and an institutional culture that promotes shared responsibility for documentation quality. These elements are essential for establishing a safer, more standardized, and patient-centered clinical handover model.

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## SAFETY CULTURE

Baek, H. H., Cho, H., Han, K., & Heo, H. (2025). [The mediating role of speak-up climate in the relationship between nurse managers' inclusive leadership, patient safety, and nurse job outcomes](#). *International Nursing Review*, 72(4), e70126.

**AIM:** To examine how nurse managers' inclusive leadership is related to patient safety and nurse job outcomes among Korean hospital nurses and to determine whether speak-up climate mediates these relationships. **BACKGROUND:** Although inclusive leadership has been linked to lower turnover intention and enhanced patient safety, the mechanisms underlying these associations remain unclear. Speak-up climate, defined as a shared perception that voicing concerns is safe and encouraged, may be a key explanatory factor. **CONCLUSION:** Strengthening inclusive leadership and cultivating a supportive speak-up climate may enhance patient safety and contribute to a more satisfied nursing

workforce. **IMPLICATIONS FOR NURSING:** Training that fosters inclusive behaviors and voice-inviting routines may strengthen speak-up climate, enhance safety perceptions, and support satisfaction and retention. **IMPLICATIONS FOR NURSING POLICY:** Beyond leadership development, institutionalizing a speak-up climate at organizational and policy levels, for example, through national safety benchmarks, can provide a strategic path toward safer and more sustainable healthcare systems.

**Bong, Y. L., Chew, K. S., Sim, S. K., Lee, S. W. F., & Tan, P. C. S. (2025).** [Perception of patient safety culture among perioperative staff: Exploring the roles of individual factors and organizational factors](#). *BMC Health Services Research*, 25(1), 1313.

**BACKGROUND:** Patient safety is a fundamental concern in healthcare, especially in high-risk settings such as operating theaters, where there is an increased likelihood of adverse events. Nonetheless, studies within the operating theater setting remain limited. This study examined the influence of organizational and individual factors, and the moderating effects of job position, gender, and experience toward patient safety culture among perioperative staff at Sarawak General Hospital (SGH) in Malaysia. **CONCLUSION:** Overall, the perception of patient safety culture in the SGH operating theater was perceived as moderate, with substantial room for improvement. The lowest positive response rate in the management dimension implies the need for the organization to address staffing shortage issues and improve workplace support to increase patient safety. Individual factors, such as job satisfaction and stress recognition, were significantly associated with these perceptions. With a coefficient of determination ( $R^2$ ) value of 42.6% in this structural model, additional influencing factors may be relevant. Future studies should explore influences such as government policies, budget allocation, and technological advancements to further enhance patient safety culture in operating theaters.

**Collado-Gonzalez, B., Urtubia-Herrera, V., Navarta-Sanchez, M. V., Sanz-Garcia, A., & Palmar-Santos, A. M. (2025).** [Safety culture in paediatric emergency departments: A cross-sectional study among healthcare professionals](#). *BMJ Open*, 15(10), e105434.

**OBJECTIVES:** Safety culture is essential to improving healthcare quality. Paediatric emergency departments are high-risk environments where evaluating safety culture helps identify areas for improvement. This study aimed to analyse the safety culture among professionals in paediatric emergency departments, according to job category and gender. **CONCLUSIONS:** Safety culture in paediatric emergency departments is acceptable, but still far from excellent, indicating ample room for improvement. Differences between professional categories, especially between paediatricians and nurses, highlight the need for targeted safety strategies and leadership involvement.

**Ergun Arslanli, S., Altundal Duru, H., Unal, E., & Sheehy, K. (2025).** [The impact of clinical nurse leadership models on the quality of care at the unit level: A systematic review](#). *BMC Nursing*, 24(1), 1295.

**BACKGROUND:** Effective leadership is one of the most critical factors in achieving successful outcomes for an organization. Therefore, modern healthcare needs effective clinical nurse leadership to improve the quality of care. This study aimed to analyse the effectiveness of clinical nurse leadership models and the impact that these models have on the quality of care at the unit level. **CONCLUSION:** There is a positive association between clinical nurse leadership style and quality of care. However, future investigation of various clinical leadership models is required to test the best mechanisms to implement clinical leadership in nursing practice. Findings provide encouraging support for the conceptualization of clinical nurse leadership models at the unit level for nurse leaders. The organizational policies regarding the competencies of clinical nursing leaders needs to be improved to increase the quality of care at the unit level. Features of clinical nurse leadership models that have a positive impact on quality of care, should be taught in practice and academic environments.

**Onyejesi, C. D., Elsayed, S. M., Daniel Isaac, J. M., Abady, E. M., Shehada, W., Alhaddad, J., &**

**Alsabri, M. (2025). [Improving patient outcomes through quality improvement and safety culture interventions in pediatric emergency care: A systematic review of best practices](#). *International Journal of Emergency Medicine*, 18(1), 217.**

Pediatric emergency departments (PEDs) are high-risk environments where patient injury can result from delays, unclear diagnoses, and poor communication. Quality improvement (QI) and safety culture initiatives are increasingly being used to improve outcomes, but their interaction in PEDs remains underexplored. This systematic review and meta-analysis evaluated how safety culture and QI initiatives impact clinical and functional outcomes in PEDs. In accordance with Preferred Reporting Items for Systematic Reviews and Meta-Analyses (PRISMA) guidelines, we systematically searched PubMed, Cochrane, Scopus, and Web of Science through December 2024. We included 31 studies, most of which used pre/post designs; one was a randomized controlled trial. Most interventions aimed to improve care in PEDs by focusing on protocol standardization, safety checklists, simulation-based training and leadership engagement tailored to the pediatric emergency department (PED) setting. Meta-analyses showed a significant decrease in unnecessary radiation exposure (6.45%-20.55%;  $p < 0.0001$ ) and PED length of stay (LOS) (~25 minutes;  $p < 0.05$ ). Additional findings included decreased healthcare expenses, unnecessary interventions, and better patient flow. Most studies were at moderate risk of bias across the assessed domains with ROBINS-I tool. These findings suggest that QI techniques can significantly improve the quality and efficiency of care when supported by a strong safety culture. These results show how essential it is to bring together both practical processes and cultural changes to build reliable, lasting systems that truly meet the unique needs of PEDs.

**Yousofvand, V., Sani, N., Khazaei, S., & Torabi, M. (2025). [The relationship between professional moral courage and patient safety silence among nurses](#). *BMC Nursing*, 24(1), 1286.**

**BACKGROUND:** Patient safety silence—the deliberate withholding of concerns or observations related to patient safety—has emerged as a critical barrier to ensuring safe healthcare delivery. Among nurses, patient safety silence in the face of safety errors may result in adverse outcomes for patients. Given the ethical nature of speaking up, identifying psychological and moral determinants, such as professional moral courage, is essential. Therefore, this study aimed to examine the relationship between professional moral courage and patient safety silence among nurses. **CONCLUSION:** Professional moral courage was found to have an inverse association with patient safety silence and remained a significant predictor even after adjusting for other factors. Male gender, longer experience, and job satisfaction reduced patient safety silence, while insufficient ethics education, night shifts, high workload, and burnout increased it. Therefore, strengthening professional moral courage through education and support may help reduce patient safety silence and improve safety culture in healthcare.

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## HUMAN FACTORS

**Gao, W., Fan, G., Liu, D., & Fan, G. (2025). [Long-term effects of structured microbreak interventions on musculoskeletal health, psychological wellbeing, and patient safety among operating room nurses: A multicenter longitudinal cohort study](#). *Journal of Healthcare Leadership*, 17, 527–548.**

**Background:** Operating room (OR) nurses frequently experience work-related musculoskeletal disorders (MSDs) and psychological strain due to prolonged static postures, repetitive movements, and high-stress conditions. While short-term benefits of microbreak interventions have been demonstrated, evidence on their long-term effectiveness and impact on patient safety remains limited. This study aimed to evaluate the sustained effects of structured microbreaks on MSD outcomes, psychological wellbeing, and patient safety, and to explore organizational factors influencing intervention adherence. **Conclusion:** Structured microbreaks yielded sustained improvements in MSD outcomes, psychological wellbeing, and patient safety, with organizational support and adaptability proving crucial for long-term success. Integrating microbreaks into routine OR workflows may enhance nurse health, reduce errors, and improve patient

care quality, offering a strategic, resource-feasible intervention for high-stress healthcare settings. Findings support embedding microbreaks into standard operating procedures and orientation, using leadership role-modeling, brief "buddy" coverage, and lightweight prompts to optimize fidelity at scale.

**Oner, B., Cokelek, F., Caliskan, N., & Duygulu, S. (2025).** [Risks posed by nurses' working hours in the intensive care unit: A systematic review.](#) *BMC Nursing*, 24(1), 1319.

**BACKGROUND:** Nurses in intensive care units often work long shifts, leading to significant physical and mental strain. This strain can negatively impact their well-being and the quality of care they provide to patients. **AIM:** To evaluate the associations between nurses' working hours in intensive care units and outcomes related to risk identification, nurse well-being, patient safety, and institutional performance. **CONCLUSION:** The review highlights the importance of addressing the risks associated with long working hours in intensive care units. The primary risks identified include nurse-focused issues such as the development of sleep disturbances and increased burnout, as well as patient-focused risks like medication errors. These risks, along with their frequency and impact, underscore the need for improved scheduling and working conditions to ensure patient safety and nurse well-being

**Villalon, F., Hirmas, A., Mundt, A. P., & Quiroz, D. (2025).** [Effectiveness of a mindfulness- and compassion-based online intervention for physician burnout: A randomized controlled trial with mediation and clinical outcome analyses.](#) *General Hospital Psychiatry*, 97, 96–104.

**BACKGROUND:** Physician burnout remains a persistent global challenge, yet most mindfulness-based interventions are limited by small samples, short follow-up, and lack of ethical integration. This study evaluated the efficacy of a culturally adapted, ethically grounded mindfulness- and compassion-based program (IBAP) in reducing burnout among physicians. **CONCLUSION:** IBAP produced large, sustained reductions in physician burnout, with effects confirmed across sensitivity analyses. The program also reduced perceived medical errors via burnout reduction, supporting its clinical relevance and scalability.

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## NEAR MISSES, NEVER EVENTS & MEDICATION ERRORS

**Abosheisha, M., Hafez, A., & Omar, I. (2025).** [Assessment of the trends of never events across NHS England: A six-year analysis.](#) *International Journal for Quality in Health Care*,

**BACKGROUND:** Never Events (NEs) are serious clinical incidents. Assessing the trends of these incidents over the years will help direct efforts towards specific areas for improvement. The NHS has made significant efforts in this direction by introducing the National Safety Standards (NatSSIPs) in 2015 and updating them in 2023. This study aims to assess the trends of the common themes of NEs and highlight potential solutions in the available literature and NatSSIPs. **CONCLUSIONS:** An assessment of the trends of NEs provides a clear picture of the current situation, highlighting areas for improvement and further work. This analysis provides a baseline for assessing the effectiveness of the updated version of NatSSIPs in future work.

**Agwunobi, A. J., Seeley, A. E., Tucker, K. L., Bateman, P. A., Clark, C. E., Clegg, A., . . . Barnes, R. K. (2025).** [Understanding structured medication reviews delivered by clinical pharmacists in primary care in England: A national cross-sectional survey.](#) *BMJ Open*, 15(9), e097012.

**OBJECTIVES:** This study explored how Structured Medication Reviews (SMRs) are being undertaken and the challenges to their successful implementation and sustainability. **CONCLUSIONS:** These results offer insights into the role being played by the clinical pharmacy workforce in a new country-wide initiative to improve the quality and safety of care for patients taking multiple medicines. Better patient preparation and trust, alongside continuing professional development, more support and oversight for clinical pharmacists conducting SMRs, could lead to more efficient medication reviews. However, a

formal evaluation of the potential of SMRs to optimise safe medicines use for patients in England is now warranted.

Khalil, H., Bell, B. G., Keers, R. N., Lewis, P. J., Foreman, M., Taylor, A., . . . Avery, A.

J. (2025). [Systematic review examining the effectiveness of professional, organisational and structural interventions in primary care to reduce medication-related hospitalisations and deaths](#). *Drug Safety*,

**BACKGROUND:** Medication-related adverse events in primary care are a leading cause of hospital admissions and mortality, commonly resulting from medication errors. Previous reviews have assessed interventions broadly across healthcare settings, but few have focused specifically on interventions targeting medication errors in primary care. **CONCLUSION:** Organisational and structural interventions in primary care may reduce medication-related hospital admissions and may help inform clinical practice through implementation of multidisciplinary care models and system-level quality monitoring approaches. However, the overall certainty of evidence is low to very low, highlighting the need for high-quality trials to better inform clinical practice and policy.

Koike, D., Ito, M., Tomomatsu, K., Shindo, R., Miyashita, T., Yamakami, J., . . . Yamada, S. (2025). [The impact of patient information on prescribing errors: Insights from pharmaceutical interventions](#). *Exploratory Research in Clinical and Social Pharmacy*, 20, 100665.

**Background:** Medication errors are more likely to occur in patients with complex conditions, where appropriate prescribing requires accurate and comprehensive patient information. Inadequate use of such information, such as overlooking laboratory results or patient weight, can lead to dosing errors or contraindicated prescriptions, even with electronic checking systems. This study aimed to analyze prescribing errors detected through pharmaceutical interventions, focusing on the patient information in the hospital information system. **Conclusion:** Laboratory data were the most frequently used information source, to prevent prescribing errors. The risk heatmap demonstrated weekends, pediatric patients, and renal dosing as high-risk areas. These findings suggest that future information systems should enhance the utility of laboratory data and incorporate tailored alerting strategies focused on high-risk patient conditions and clinical settings, such as real-time lab data alerts or weight-based dosing calculators, and potentially explore the use of AI for proactive error prevention.

Mumford, V., Raban, M. R., Fitzpatrick, E., Woods, A., Merchant, A., Badgery-Parker, T., . . .

Westbrook, J. I. (2025). [Harm to children from prescribing and administration errors in acute care: A multidisciplinary panel assessment](#). *Drug Safety*,

**INTRODUCTION:** Medication errors continue to cause inpatient harm in children and can be difficult to both identify and classify. Medication error studies often focus on assessing potential harm and there is little published data on actual harm from medication errors in children. **CONCLUSIONS:** We found higher rates of actual harm associated with medication errors in younger patients, wrong dose prescribing errors and intravenous antibiotic administration errors. These important findings provide opportunities for developing tailored interventions targeting identified high-risk areas to enable the successful reduction of preventable harms in paediatric patients.

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## REPORTING SYSTEMS

**Baek, O., & Shin, S. (2025). [Development and internal validation of the patient safety experience scale for inpatients](#). *PLoS ONE [Electronic Resource]*, 20(10), e0332133.**

There is an increasing need for a practical instrument that captures patient safety experiences from the inpatient perspective and is suitable for clinical application. This study aimed to develop a Patient Safety Experience Scale (PSES) reflecting inpatient safety indicators and to evaluate its reliability and validity. An initial pool of 90 items was generated through a literature review and qualitative interviews, from which 60 items were selected based on expert evaluation and content validity assessment. A survey was conducted among 549 inpatients. Data were analyzed using item analysis, confirmatory factor analysis, Pearson's correlation, Cronbach's alpha, and intraclass correlation coefficients (ICC) using SPSS 26.0 and AMOS 21.0. The final scale comprised 30 items across six factors: patient identification, prevention of medication errors, fall prevention, infection prevention, compliance with safety in daily life, and information sharing. The PSES demonstrated excellent internal consistency (Cronbach's alpha = .95) and strong test-retest reliability (ICC = .89). Additionally, it showed strong concurrent validity with the patient participation scale, with a correlation coefficient of .91. These findings support the internal validity of the PSES as a reliable and feasible instrument for systematically assessing safety experiences of inpatients. This scale may facilitate targeted quality improvement efforts and contribute to fostering a patient-centered safety culture in healthcare settings.

**Beecham, E., Brady, G., Iqbal, S., Fatima, Q., Arshad, S., Bondaronek, P., . . . Vindrola, C. (2025). [Systematic review of patient safety incident reporting practices in maternity care](#). *BMJ Open Quality*, 14(4)**

**PROBLEM:** Patient safety incident reporting in maternity care is central for improving safety, yet inconsistencies in reporting practices and limited understanding of system functionalities may reduce its effectiveness. **BACKGROUND:** Reporting incidents allows healthcare providers to identify safety issues and implement improvements. However, variations in reporting practices, particularly in maternity care, have been found across different healthcare settings. Despite the growing use of electronic systems, challenges such as under-reporting, lack of feedback and insufficient organisational learning persist. **CONCLUSION:** Improving patient safety incident reporting in maternity care requires system improvements, cultural changes and further research to address identified gaps and optimise incident management systems.

**Hall, J., Atmore, K. H., Belikova, R., Boyd-Skinner, C., Corrigan, L., Giannaki, A., . . . Breda, J. (2025). [Development of methods for WHO quality standards for child and youth mental health services to improve quality of care and patient safety in the WHO European region](#). *Frontiers in Health Services*, 5, 1644419.**

**Background:** Child and youth mental health care is of varying quality across the WHO European Region, with many settings being low-resourced. To improve and standardize quality of care, WHO Regional Office for Europe is developing quality standards for child and youth mental health services. This research aims to develop evidence informed methods to develop these quality standards. **Discussion:** The methods taken to develop quality standards need to be rigorous to ensure that standards accurately define high-quality care for a service. There is a need to develop a unified approach to developing quality standards. It is hoped that this paper will provide inspiration for others developing quality standards for child and youth mental health services and spark research in this area.

**Kakemam, E., Mardani, A., Parsarad, E., Taheri, R., Moosavi, S., Kalhor, R., & Roh, Y. S. (2025). [The impact of nurses' perceptions of systems thinking on patient safety competencies: A cross-sectional study](#). *BMC Health Services Research*, 25(1), 1233.**

**BACKGROUND:** Systems thinking-conceptualized as an approach for understanding the dynamic interactions and interdependencies among components within complex systems such as healthcare-has been widely recognized in the literature as a critical framework for strengthening patient safety

competencies (PSCs). Despite this recognition, empirical studies specifically examining the impact of systems thinking on nurses' PSCs remain limited. Accordingly, the present study aims to examine the relationship between systems thinking and PSCs among Iranian nurses. **CONCLUSION:** Nurses in the study population demonstrated moderate levels of both systems thinking and PSCs. These findings underscore the critical role of systems thinking in enhancing nurses' PSCs. The results can serve as a foundational basis for the formulation of hospital policies aimed at bolstering nurses' PSCs, thereby contributing to improved patient safety within healthcare settings. Policies and interventions on promoting systems thinking among nursing staff must be created and implemented. However, further studies using robust designs, including longitudinal and intervention research designs, are needed to examine the effect of systems thinking to enhance PSCs in nurses working in hospitals.

**Koskiniemi, S., Syyrila, T., Hameen-Anttila, K., & Harkanen, M. (2025). [Handling features of patient safety incident reporting software and shortcomings in report processing from healthcare professionals' perspectives: A cross-sectional study with a qualitative design](#). *Journal of Nursing Management*, 2025, 6724890.**

**Background:** Patient safety incidents are underreported, and report handlers, usually unit managers, are dissatisfied with the incident reporting software's handling features. **Conclusion:** The findings indicate that it is time to critically evaluate the usefulness of reporting software. Incident report handlers need optimum tools to process valuable client and patient safety information. Furthermore, incident report processing procedures require changes to assure reporters that it is meaningful and secure to report all patient safety incidents they observe or are involved in. **Implications for Nursing Management:** This study highlights the need for improvements in incident reporting software from the perspective of report processing. Additionally, report processing structures and methods must be clarified.

**Mesinioti, P., Macrae, C., Sheard, L., Hampton, S., Louch, G., & O'Hara, J. (2025). [Closing investigations: The role of national policy in shaping structural, organisational and relational constraints on learning from patient safety incidents](#). *Safety Science*, 192, None.**

This study aimed to understand the role of a national patient safety policy, the Serious Incident Framework, on local organisational practices of responding to, investigating, and learning from patient safety incidents in the National Health Service (NHS) in England. Qualitative interviews were conducted with healthcare professionals in six NHS organisations and analysed using inductive thematic analysis and taking a constant comparison approach. Systemic challenges linked to the policy's prescriptive requirements were identified, including its emphasis on metrics such as incident closure and harm levels, which often obscured meaningful learning and systemic improvement. The findings highlight the misalignment between the policy's key aims and principles and its practical implementation, revealing an 'industry of investigations' that risked turning the investigative process into a compliance-oriented 'tick box exercise'. Furthermore, the overspecification of performance requirements coupled with the underspecification of substantive guidance led to variability in investigative processes, organisational capacity and resources, and investigator training and expertise. The involvement of patients and families affected by safety incidents was found to be inconsistent and often limited, with perceptions of senior managers and frontline staff underlining some tensions in operationalising large patient safety policies. The analysis considers how the development and implementation of national safety incident policies needs to carefully and intelligently balance the need for adaptive flexibility, clarity of guidance, and specification of organisational resourcing and infrastructure to ensure future national policy can effectively support local practices of learning from safety incidents.

**Moon, J. Y., Welp, C., Nold, M., Nienow, J., Rader, T., Ramar, K., & Cowart, J. B. (2025). [Optimizing event reporting to drive a culture of learning and safety: A system-based approach to mitigating harm through near-miss and no-harm reporting](#). *Journal of Patient Safety*,**

**BACKGROUND:** Patient safety event reporting systems are essential for identifying potential risks and improving patient outcomes. However, traditional systems frequently face issues of under-reporting,

particularly concerning near-miss and no-harm events, thereby limiting opportunities for organizational learning and harm prevention. This initiative used quality improvement principles to design a new reporting system at our institution to enhance safety culture. **CONCLUSIONS:** The new reporting system has improved reporting overall, with increases in near-miss and no-harm events, along with increased staff engagement with the reporting and review process. Our experience offers practical lessons for institutions seeking to strengthen the learning value of event reporting systems. The principles we identified with simplifying ease of use, integrating into the EHR, improving data transparency, and encouraging greater involvement with event review, along with clear oversight protocols, apply beyond our institution and are not limited to a specific PSRS product or system. These initial outcomes support a culture of safety and bolster organizational learning, with future study needed on long-term effects on patient safety outcomes, staff involvement, and increased trust.

Ravaghi, H., Ahmadi, F. Z., Khatooni, E., Khani, S., Ahmadnezhad, E., & Abdi, Z. (2025). [Patient and family engagement in patient safety efforts in low-resource settings: A scoping review](#). *BMJ Open*, *15*(10), e100907.

**OBJECTIVES:** Patient and family engagement in patient safety in low- and lower-middle-income countries (LLMICs) is not well described. This scoping review synthesised the literature to identify key strategies, barriers and enablers of engagement and to explain how patients and families contribute to safety efforts in healthcare settings. **CONCLUSION:** Despite its potential benefits, the implementation and impact of patient and family engagement in patient safety efforts in LLMICs remain largely unexplored. Most efforts focus on information sharing through educational interventions at the direct care level, with limited involvement of patients and families at the partnership level. To enhance safety outcomes, future initiatives must adopt context-specific strategies that empower patients and families as active partners. Drawing lessons from high-income countries and adapting them to the socio-cultural and infrastructural realities of LLMICs will be crucial for developing scalable, cost-effective and sustainable engagement practices.

Roos, R., Zwaan, L., Maranus, M., Meynaar, I. A., Valk, V. J., van Nieuwkoop, C., . . . van Aken, M. O. (2025). [A safety-II approach to learn from practice variation in the diagnostic process in the emergency department: An action research study](#). *Diagnosis*,

**OBJECTIVES:** The focus on improving patient safety has mainly been by learning from errors and near misses (Safety-I). We applied a novel Safety-II approach to identify and learn from practice variations in the diagnostic process in the emergency department (ED), and subsequently design and implement practice changes. **CONCLUSIONS:** A Safety-II approach with action research and direct observations of the diagnostic process in the ED can be successfully applied to identify and learn from practice variation, and can lead to well-received practice changes.

Wilde, M., Agarwala, A. V., Thomas, B. J., & Brook, K. (2025). [Sharing is caring: The importance of transparency in adverse events](#). *Current Opinion in Anaesthesiology*, *38*(6), 754–761.

**SUMMARY:** There has been much progress nationally in enhancing the transparency of adverse events. Future areas of improvement include cross-institutional transparency and facilitating the timely sharing of repeat concerns and lessons learned from national registries back with participating institutions and departments. Concerns about legal consequences when discussing adverse events may prohibit expanded transparency.

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**SIMULATION, EDUCATION, AI, TECHNOLOGY,  
GAMIFICATION**

**Alkhatib, S. A., Katmah, R., Kosaji, D., Afzal, S. U. B., Tariq, M. H., Simsekler, M. C. E., & Ellahham, S. (2025). [AI-driven decision support framework for preventing medical equipment failure and enhancing patient safety: A new perspective](#). *Journal of Multidisciplinary Healthcare*, *18*, 6299–6313.**

Medical equipment failures pose serious risks to patient safety and healthcare system efficiency. Although AI-based predictive maintenance (PdM) has shown promise in other industries, its application in healthcare remains fragmented and insufficiently aligned with human-centered principles. This perspective paper proposes a novel AI-driven decision support framework that integrates systems thinking and prioritizes human-centered design. By leveraging real-time sensor data and historical maintenance records, the framework proactively predicts equipment failures and reduces downtime. It incorporates insights from key stakeholders, including biomedical engineers, technicians, patients, and administrators, to ensure human-centered and ethically responsible implementation. The paper also addresses major challenges such as data integration, human factors, and organizational readiness, offering practical strategies for sustainable adoption. This work contributes to the evolving role of AI in healthcare by emphasizing empathy, stakeholder collaboration, and safety, ultimately promoting more reliable medical devices and improved patient outcomes.

**Amini Rarani, S. (2025). [Smart technologies and digital innovations for improving perioperative patient safety: A review](#). *Patient Safety in Surgery [Electronic Resource]*, *19*(1), 31.**

Smart digital technologies are rapidly transforming perioperative care through tools such as clinical decision support systems, wearable sensors, and electronic checklists. Despite growing adoption, their specific impact on patient safety in the operating room remains insufficiently understood. This narrative review explores recent advancements in perioperative digital health and examines how innovations like AI-assisted systems, electronic WHO checklists, and physiological monitoring wearables contribute to safer surgical care. The evidence suggests that these tools can enhance complication detection, protocol adherence, and team communication. However, their effectiveness is tempered by challenges including alert fatigue, fragmented data systems, and added digital workload for healthcare staff. To realize their full potential, future implementations must prioritize usability, interoperability, and seamless workflow integration. Rigorous clinical trials and cost-effectiveness studies are also needed to establish the true value of smart technologies in improving surgical patient outcomes.

**Corona-Pantoja, A. C., Rodelo-Uraga, M. F., Barreto-Navarro, D. M., Davalos-Higareda, I. S., Zamora-Gonzalez, E. O., Castro-Navarro, A. R., . . . Lopez-Hernandez, L. B. (2025). [Enhancing patient safety awareness among medical students: A pilot study](#). *Quality Management in Health Care*,**

**BACKGROUND AND OBJECTIVES:** The practice of medicine involves the risk of causing harm, even under the best circumstances and despite having optimal training. Therefore, patient safety is not only an essential part of healthcare but is also crucial for the training of resilient future doctors. The awareness of medical students regarding patient safety issues is of utmost importance for their professional formation. The objective of the present study was to gain insights into the awareness of medical students at the Autonomous University of Guadalajara about patient safety problems and the expectations of how patient safety is being managed in the health system. **CONCLUSION:** Students showed satisfactory awareness and positive expectations with regard to reporting and learning from errors and helping others when medical errors occur, which has implications for health care quality. Application of the WHO questionnaire in other settings and countries may contribute to a better comprehension of awareness and expectations of future health professionals in the world.

**Huang, E., Hart, J., & Won, J. (2025). [From SMART aims to systems thinking: Expanding the scope of quality improvement and patient safety education](#). *BMJ Quality & Safety*,**

Hur, H., Choi, J., & Jung, J. (2025). [Effectiveness of an immersive virtual reality simulation speak-up training program for patient safety in novice nurses: A quasi-experimental study](#). *Healthcare*, 13(19)

**Background/Objectives:** Novice nurses often struggle to assertively voice patient safety concerns due to limited clinical experience and hierarchical healthcare environments. Immersive virtual reality simulation (IVRS) may provide opportunities to practice assertive communication skills essential for interprofessional collaboration in a psychologically safe environment. This study aimed to evaluate the short- and long-term effectiveness of an IVRS speak-up training program in enhancing communication clarity and collaborative attitudes, as well as reducing experiences of nursing malpractice among novice nurses. **Conclusions:** The IVRS speak-up training program effectively enhanced novice nurses' assertive communication skills in immersive, interactive environments tailored for realistic practice compared to conventional group discussion-based training. This program improved communication clarity in the short term and enhanced collaborative attitudes up to 6 weeks. Integrating or boosting IVRS training into novice nurses' communication education may foster interprofessional collaboration and advance patient safety in clinical practice.

Lee, J., Huang, C., Wang, H., Hung, S., & Chang, J. (2025). [A novel approach to patient safety education: Integrating the human factors analysis and classification system \(HFACS\) to build a culture of safety in medical training](#). *BMC Medical Education*, 25(1), 1296. <https://libkey.io/libraries/2838/10.1186/s12909-025-07830-3>

**BACKGROUND:** This study evaluated the effectiveness of an educational intervention based on the Human Factors Analysis and Classification System (HFACS) in enhancing medical students' patient safety competencies. The intervention specifically targeted students' ability to identify human factors and recognize adverse events. **CONCLUSIONS:** The HFACS-based educational intervention significantly enhanced medical students' competencies in recognizing adverse events, understanding the importance of reporting, and identifying human factors across multiple system levels. These findings support the integration of HFACS into medical curricula to promote systemic thinking and foster a proactive safety culture.

Mehrdad, M., Jambarsang, S., Sadeghian, H., Jabinian, F., & Keshmiri, F. (2025). [Effects of game-based learning and flipped classroom strategies on performance and reasoning in patient safety education for surgical nursing students](#). *PLoS ONE [Electronic Resource]*, 20(10), e0334545.

**INTRODUCTION:** The present study aimed to assess the effect of game-based learning (GBL) on surgical nursing students' performance and reasoning skills in the management of patient safety incidents in surgical units compared to the flipped classroom method. **CONCLUSION:** This study demonstrates that game-based learning significantly enhances surgical nurses' reasoning skills in managing patient safety incidents compared to traditional flipped learning approaches. While the intervention group showed notable short-term performance improvements at the two-week follow-up, these gains diminished over time, suggesting a need for reinforcement strategies to sustain competency.

Redondo Calvo, F. J., Baladron Gonzalez, V., Tebar Betegon, M. A., Martinez Arce, A., Verdugo Moreno, G., Padin, J. F., . . . Bejarano Ramirez, N. (2025). [Improving good practices for patient safety in an emergency department based on multidisciplinary training using simulation techniques](#). *Nursing Reports*, 15(10)

**Background:** We present a multidisciplinary training experience based on simulation techniques and critical resource management implemented in the emergency department. **Conclusions:** For resource management in this type of crisis in the hospital emergency setting, it is essential to use a debriefing process guided by experienced instructors after a specific experiential learning experience through simulation scenarios. This helps to contextualize and analyze the advantages and disadvantages of general recommendations.

## FALLS PREVENTION

Aslam, Z. R. (2025). [Enhancing fall prevention in older adults with cancer: Integrating environmental, symptom, and caregiver-focused strategies](#). *Journal of Geriatric Oncology*, 17(1), 102719.

Batiha, A. (2025). [Nurses' knowledge, self-efficacy, and workplace support in fall prevention: A cross-sectional study](#). *Journal of Research in Nursing*, 17449871251381165

**Background:** Patient falls are a persistent safety issue in acute care settings, particularly in resource-limited healthcare environments. Nurses play a critical role in fall prevention, yet their effectiveness can be hindered by insufficient training, low self-efficacy, and lack of institutional support. **Conclusion:** Nurses' knowledge and self-efficacy are key to effective fall prevention. However, institutional support structures may not align with the needs of confident and experienced nurses. Targeted training, mentorship, and workload management are essential to improve patient outcomes. Policymakers should prioritise personalised support systems and standardised fall prevention protocols.

Cheng, M., Ni, J., Liu, F., & Wang, S. (2025). [Optimal type and dose of exercise to improve fall behavior in older adults: A systematic evaluation and network meta-analysis](#). *Ageing Research Reviews*, 113, 102924.

**BACKGROUND:** This meta-analysis aims to evaluate the effects of exercise interventions on fall rates and fall risk in older adults and identify the most effective exercise types and doses for fall prevention. **CONCLUSIONS:** The study identified the relative effectiveness of different exercise interventions in improving fall-related outcomes among older adults. Falls Management Exercise Programme (FaME) was found to be the most effective adjunctive intervention, followed by Otago Exercise Program (OEP), aquatic exercise, Tai Chi, and balance training. Providing the most effective exercise strategies may enhance fall prevention in older adults, even when the exercise dose falls below the thresholds recommended by the WHO guidelines.

H Tak, S., & Lee, D. (2025). [Fall prevention interventions for cognitively impaired older adults: A systematic literature review and meta-analysis](#). *Western Journal of Nursing Research*, 1939459251381979

**BACKGROUND:** Older adults with cognitive impairment are at increased risk of falls due to impaired judgment, balance, and mobility. The effectiveness of fall prevention interventions in this population remains unclear. **CONCLUSIONS:** Fall prevention interventions can effectively reduce fall rates among older adults with cognitive impairment. Implementing tailored, evidence-based strategies is essential to supporting this high-risk population.

Ehn, M., Revenas, A., & Tobiasson, H. (2025). [Expanding the design space for fall prevention in acute orthopedic hospital care: Human-centered design study](#). *JMIR Human Factors*, 12, e73110.

**BACKGROUND:** In-hospital fall prevention is a complex phenomenon most efficiently addressed via a wide range of multifactorial interventions. Technology may contribute, but research in this field has so far mainly focused on detecting falls. As a result, new knowledge from a system perspective is needed regarding when and how new technologies may support fall prevention among patients who have been hospitalized. **CONCLUSIONS:** The view on technology-based in-hospital fall prevention can be broadened not only to mainly include monitoring and alarm systems, information systems in general, or computer-based information in particular systems but also to support activities performed by health personnel that engage patients in fall prevention. For example, tools such as these can be implemented in training involving daily activities and mobility within safe yet more homelike clinical contexts.

Haley, M. N., Sherrington, C., Lawler, K., Harding, K. E., Lord, M., Williams, S., & Taylor, N. F. (2025). [Falling short on implementation of fall prevention guidelines in health services: A systematic review with meta-analysis](#). *Age & Ageing*, 54(10)

**BACKGROUND:** Falls are a serious risk for people who use health services. We aimed to evaluate the implementation of fall prevention guidelines in health services. **CONCLUSION:** Implementation of fall prevention guidelines in health services can change and sometimes sustain fall prevention behaviour of health professionals. It is uncertain whether implementation leads to reduced falls or changes in patient behaviour.

Jang, H., Bae, S., Yoo, J., Lee, J., Kwon, S., Jung, E., & Yim, J. (2025). [Designing and implementing a metaverse strategy for fall prevention in older adults: A theoretical review](#). *Journal of Clinical Medicine*, 14(20)

The aim of this study was to propose the use of metaverse technology as an effective educational method for fall prevention in older adults. Metaverse-based platforms, which employ virtual avatars and immersive environments, may enhance accessibility, motivation, and social connectedness. Potential applications include personalized fall prevention training, virtual community centers, and gamified group exercise environments. Augmented and mixed reality technologies may further improve realism and usability compared with traditional virtual reality. However, challenges remain, including digital literacy gaps, device costs, and infrastructure requirements. Metaverse technology therefore offers a promising platform to bridge the gap between face-to-face and remote interventions. This review is novel in that it systematically synthesizes fragmented evidence on metaverse-based fall prevention, conceptualizes its educational potential for older adults, and provides a foundation for future clinical and policy applications.

Jiang, H., Liu, H., Wu, H., Yang, Y., & Li, X. (2025). [A real-world study on the morse fall scale and clinical judgment method for fall risk in adult inpatients](#). *International Nursing Review*, 72(4), e70110.

**AIM:** To compare the predictive performance of the Morse Fall Scale and the Clinical Judgment Method for Fall Risk for assessing fall risk among hospitalized adults using real-world data. **CONCLUSION:** Both tools demonstrate good predictive performance for fall risk in adult inpatients and demonstrate complementary strengths in fall risk assessment. The Morse Fall Scale showed higher specificity and is better suited for detailed stratified management, while the Clinical Judgment Method offered higher sensitivity and efficiency for rapid screening and patients with a single high-risk factor for falls. Based on these findings, we propose that a two-stage "screening-confirmation" model combining both tools may enhance clinical fall risk management; however, this approach requires further validation in future studies.

Manning, F., Ventre, J. P., Brough, G., Hawley-Hague, H., Hulme, C., Kendrick, D., . . . Goodwin, V. A. (2025). [Mediators implementation and delivery: The falls management exercise programme \(FaME\)](#). *BMC Health Services Research*, 25(1), 1396.

**BACKGROUND:** When implementing multicomponent interventions, fidelity to the intervention is key for reproducible outcomes. This study investigates the main influences on the fidelity (implementation strategy fidelity and intervention delivery fidelity) of the community-based Falls Management Exercise (FaME) programmes in three different areas of England. **CONCLUSION:** Despite a recognised need for implementing evidence-based falls prevention programmes, a lack of sufficient funding, formalised oversight roles/structures and understanding of essential intervention components is associated with lower fidelity to the intervention. Unchecked by local monitoring, this can lead to an incremental migration of delivery away from the evidence base. We recommend: (i) providers have clarity on essential intervention components, (ii) standardised fidelity monitoring based on essential components, and (iii) effective local oversight roles and structures.

McCray, S., & Gilewicz, D. (2025). [Interdisciplinary communication to prevent toileting-related falls. \*Rehabilitation Nursing Journal\*.](#)

**BACKGROUND:** Toileting and ambulation have been identified as common activities associated with patient falls. Furthermore, miscommunication among health care teams was identified as a key contributing factor in falls resulting in injury. **CONCLUSIONS:** Nurse leaders and interdisciplinary teams can reduce toileting-related falls and enhance the culture of safety by standardizing the communication of supervision needed while toileting. A careboard utilizing the colors similar to a stoplight as a form of communication can facilitate effective interdisciplinary communication regarding the supervision level required during toileting.

Zhong, Y., Guo, W., Chen, P., & Wang, Y. (2025). [Effects of core training on balance performance in older adults: A systematic review and meta-analysis. \*Frontiers in Public Health\*, 13, 1661460.](#)

**Background:** Core training (CT) has been increasingly recognized as a promising intervention for improving balance in older adults, a demographic particularly susceptible to falls and fall-related injuries. This systematic review and meta-analysis sought to evaluate the efficacy of CT on balance in older adults, providing substantial evidence to establish its role in fall prevention strategies. **Conclusion:** CT is a highly effective intervention for enhancing balance in older adults, supporting its integration into fall prevention programs. However, given the heterogeneity across studies, further rigorously designed trials with standardized intervention protocols and outcome measures are necessary to confirm the long-term benefits and optimal parameters for balance enhancement.

#### Research studies/clinical trials

Faria, J. O., Favretto, M. E. C., Bezerra, I. S., Santos, T. F., Lemos, T. W., Villalba, M. M., . . . Moraes, R. (2025). [Effect of perturbation-based balance training distribution on stability and fall risk in faller older adults: A randomized single-blind clinical trial. \*Human Movement Science\*, 104, 103415.](#)

Mozhu, L., & Jiayu, L. (2025). [Effects of 16-week tai chi practice on sit-to-stand performance and lower-limb neuromuscular control strategies in community-dwelling older adults: A randomized controlled trial. \*Frontiers in Physiology\*, 16, 1681591.](#)

Naderer, M., Kim, Y., Kim, T., & Kim, Y. (2025). [Development and control of a robotic assistant walking aid for fall risk reduction. \*Frontiers in Robotics & AI\*, 12, 1646803](#)

Sheikhbahaie, S., Sahebozamani, M., Bahiraei, S., Hosseinzadeh, M., & Alimoradi, M. (2025). [The effect of 8 weeks of pickleball program on balance, spatiotemporal gait parameters, and psychosocial factors in older adult women: A single-blinded randomized controlled trial. \*Journal of Aging & Physical Activity\*, 1-11](#)

Wang, C., Liang, C., Teng, M., Chia, P., Lee, Y., Chang, S., . . . Mu, P. (2025). [Person-centered falls prevention and management in neurological post-operative patients: A best practice implementation project. \*JBI Evidence Implementation\*, 23\(4\), 462–473.](#)

Willemse, L., Wouters, E. J. M., Pisters, M. F., & Vanwanseele, B. (2025). [Effects of a 12-week intrinsic foot muscle strengthening program \(STIFF\) on gait, balance and concerns about falling in physically active older adults: An assessor-blinded randomized-controlled trial. \*Gait & Posture\*, 123, 110018.](#)

Yang, J., Mao, T., Zhou, L., Li, N., Wu, H., Wang, Q., . . . Chen, B. (2025). [The impact of using "teaching, exercising, and practicing" three-step training mode on the performance and](#)

[satisfaction of internship nursing students in the training of fall prevention education ability: A randomized controlled trial. \*BMC Nursing\*, 24\(1\), 1316.](#)

Yap, J., Broman, P., Longhurst, G., & Brownie, S. (2025). [Student-run falls prevention programmes for older adult community members: A pilot study. \*Journal of Primary Health Care\*, 17\(3\), 276–280.](#)

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## SEPSIS

Huang, P., Liu, T., Wu, J., Tsai, Y., Hsu, W., Chuang, M., . . . Lai, C. (2025). [Effect of ultrashort-acting beta-blocker on the mortality of patients with sepsis or septic shock: A systematic review and trial sequential meta-analysis of randomized controlled trials. \*Intensive & Critical Care Nursing\*, 92, 104265.](#)

**BACKGROUND:** Adrenergic responses, particularly tachycardia, play a role in sepsis-related complications. Ultrashort-acting beta-blockers have been evaluated in randomized controlled trials (RCTs) for their impact on sepsis outcomes, but conflicting results have been reported. This systematic review and meta-analysis aim to provide an updated perspective on the impact of ultrashort-acting beta-blockers on the clinical outcomes of sepsis. **CONCLUSIONS:** Adjuvant ultrashort-acting beta-blocker therapy demonstrated potential benefits in improving survival for patients with sepsis or septic shock. **IMPLICATIONS FOR CLINICAL PRACTICE:** This study highlights the potential benefits of adjuvant ultrashort-acting beta-blocker therapy for the treatment of sepsis or septic shock in terms of enhanced survival and other clinical advantages, including reduced heart rate and cardiovascular biomarkers. Furthermore, such therapy did not appear to impair cardiac function and hemodynamic stability.

Smet, H., Hirt, J., Hahnloser, D., & Grass, F. (2025). [Surgical approach to intraabdominal sepsis: A damage control approach can reduce stoma rates. \*Surgical Endoscopy\*,](#)

**BACKGROUND:** In patients with perforated diverticulitis and/or intraabdominal sepsis (IAS), the best surgical strategy remains controversial. While open, non-restorative Hartmann's procedure represents the procedure of choice in many centers, ostomy-sparing and minimally invasive techniques have been increasingly utilized due to short- and long-term benefits, including a reduced stoma rate. This dynamic manuscript illustrates strategic and technical considerations of the standardized institutional staged or damage control approach to IAS. **CONCLUSION:** A staged approach according to a predefined decisional framework may help decrease the need for ostomy creation in patients with IAS.

Wrzosek, A., Drygalski, T., Nowak, L., Grabowska, I., Wordliczek, J., Terlecki, M., & Garlicki, J. (2025). [Is there a rationale for haemoabsorption with combined use of CytoSorb<sup>®</sup> and oxiris<sup>®</sup> in patients with underlying viral infection and secondary bacterial sepsis?. \*Journal of Clinical Medicine\*, 14\(19\)](#)

**Aim:** The rationale for combining various extracorporeal blood purification techniques to improve patient outcomes is currently being discussed extensively. The combined use of CytoSorb<sup>®</sup>, with high capacity for cytokine removal, and Oxiris<sup>®</sup>, which adsorbs endotoxins and smaller cytokines, may enhance the efficacy of blood purification in sepsis. **Conclusions:** Our data suggests that combined use of Oxiris<sup>®</sup> and CytoSorb<sup>®</sup> for simultaneous cytokine and endotoxin removal in patients with underlying viral infection may be a promising therapeutic option. Our findings may serve as a guide for future research and provide directions for further development in this field.

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