

CURRENT AWARENESS BULLETIN



PATIENT SAFETY

October 2023



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Thank you.

BREAKING NEWS

➔ Curtis, P. and Wood, C. (2023) [‘Martha’s Rule: A new policy to amplify patient voice and improve safety in hospitals’](#)

Martha Mills died aged 13 in the summer of 2021 after sustaining a pancreatic injury from an everyday bike accident. The inquest into her death heard that she would likely have survived the sepsis that killed her had consultants made a decision to move her to intensive care sooner. This report is a response to the call from Martha Mills’s parents to rebalance the power between patients and medics to improve patient safety. It comes amidst significant evidence that shows that failing to properly listen to patients and their families contributes to safety problems in the NHS, along with public awareness among citizens that the NHS can feel unresponsive at times.

➔ WHO (17/09/2023) [‘WHO - World Patient Safety Day’](#)

World Patient Safety Day 2023 was observed on 17 September under the theme "Engaging patients for patient safety", in recognition of the crucial role patients, families and caregivers play in the safety of health care. Evidence shows that when patients are treated as partners in their care, significant gains are made in safety, patient satisfaction and health outcomes. By becoming active members of the health care team, patients can contribute to the safety of their care and that of the health care system as a whole.

➔ Medicines and Healthcare Products Regulatory Agency (2023) [‘National patient Safety Alert Medical beds, trolleys, bed rails, bed grab handles and lateral turning devices: risk of death from entrapment or falls’](#)

The MHRA continues to receive reports of deaths and serious injuries from entrapment or falls

relating to medical beds, bed rails (also known as bed safety rails), trolleys, bariatric beds, lateral turning devices and bed grab handles (also known as bed levers or bed sticks). Includes risk factors and actions required.

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COMMUNICATION

- ❖ Campbell, K. et al (30/08/2023) '[The Impact of Virtual Consultations on the Quality of Primary Care: Systematic Review](#)', *Journal of Medical Internet Research*, 25, pp. e48920

This study aims to evaluate the impact of virtual consultations on the quality of primary care. The systematic review demonstrated that virtual consultations may be as effective as face-to-face care and have a potentially positive impact on the efficiency and timeliness of care; however, there is a considerable lack of evidence on the impacts on patient safety, equity, and patient-centeredness, highlighting areas where future research efforts should be devoted.

- ❖ Doornkamp, S. et al (2023) '[A controlled adaptive computational network model of a virtual coach supporting speaking up by healthcare professionals to optimise patient safety](#)', *Cognitive Systems Research*, 81, pp. 37-49.

Previous reports show that a substantial proportion of (near) medical errors in the operating theatre is attributable to ineffective communication between healthcare professionals. This paper introduces an adaptive computational model which predicts speaking up behaviour from the perspective of the speaker and receiver, with the addition of a virtual coach to further optimise patient safety when a patient could be in harm's way.

- ❖ Leahora R. et al (2023) '[Physician engagement in organisational patient safety through the implementation of a Medical Safety Huddle initiative: a qualitative study](#)', *BMJ Quality & Safety*, pp. bmjqs-015725

In this study, physicians' experience of participating in a Medical Safety Huddle initiative demonstrated how participation influences engagement with organisational quality and safety

efforts, and was found to support physician engagement in quality and safety through intrinsic motivation.

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LEADERSHIP

- ❖ Dept of Health and Social Care/NHS England and Steve Barclay (04/09/2023) '[Speech: Secretary of State oral statement on Lucy Letby statutory inquiry](#)'

The Health and Social Care Secretary delivered an oral statement in the House of Commons to update on the Lucy Letby statutory inquiry. This inquiry will examine the case's wider circumstances, including the Trust's response to clinicians who raised the alarm, and the conduct of the wider NHS and its regulators.

- ❖ Kirkup, B. and Titcombe, J. (2023) '[Patient safety: listen to whistleblowers](#)', *BMJ*, 382, pp. p1972.

Reflection on whistleblowing regarding the case of Lucy Letby, convicted of the murder of seven babies and attempted murder of another six. "Although the intentional harm underlying this gross breach of patient safety is rare, the subsequent failures to identify and acknowledge serious problems are sadly much more common." (Paywalled)

- ❖ Kotagal, M. et al (2023) '[Making a move: Using simulation to identify latent safety threats before the care of injured patients in a new physical space](#)', *The Journal of Trauma and Acute Care Surgery*, 95(3), pp. 426-431

Systems-focused trauma simulations were used to identify a large number of latent safety threats (LSTs) before the opening of a new critical care building. Identification of LSTs is feasible and facilitates mitigation before actual patient care begins, improving patient safety.

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SAFETY CULTURE

- ❖ Garay, S. et al (2023) '[Interventions to enhance safety culture for nursing professionals in long-term care: A systematic review](#)', *International Journal of Nursing Studies Advances*, 5, pp. 100119.

This systematic review aimed to identify strategies to enhance safety culture in long-term care settings and describe factors facilitating or inhibiting the process from the available evidence. Strategies found to enhance the safety culture in care settings include collegial exchange of experiences and learnings, integration of staff's perceptions, external facilitation, staff training, and a structured, multi-step procedure of the intervention process.

- ❖ Mazur, L. et al (2023) '[Assessing the Sustainability of Initiatives Aimed to Enhance Patient Safety Culture: A > 10-year Experience with Multifaceted Interventions](#)', *International Journal of Radiation Oncology, Biology, Physics*, 117(2), pp. S146.

Study regarding a series of mutually reinforcing initiatives aimed to improve operations, and patient and staff safety, and reviewing the impact of these initiatives on Patient Safety Culture over 14 years.

- ❖ Mullen, J. E. (2023) '[Recognizing Child Abuse](#)', *AACN Advanced Critical Care*, 34(3), pp. 240-245.

This column presents several vignettes with corresponding questions to give readers an opportunity to identify some abusive injury patterns, practice differentiating between accidental and inflicted injuries, and identify red flags that should raise concerns that abuse or neglect is taking place.

- ❖ Haseli, A. et al (31/08/2023) '[Midwifery students' experiences: Violations of dignity during childbirth](#)', *Nursing Ethics*.

The study explored the experiences of midwifery students regarding threats to women's dignity during childbirth. Four key themes emerged: 1) professional incompetence, 2) abuse of power imbalance, 3) caring only for physical and not mental health, and 4) structural issues within the healthcare system. The findings underscore the role that unprofessional behaviour, ethical lapses in medical practices, and systemic challenges play in undermining maternal dignity during childbirth.

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WELLBEING

- ❖ Bell, T. et al (2023) '[Fatigue in nurses and medication administration errors: A scoping review](#)', *Journal of Clinical Nursing*, 32(17-18), pp. 5445-5460.

Medication administration errors (MAEs) cause preventable patient harm; an emerging factor contributing to these errors is nurse fatigue. Given medication administration is the most frequent clinical task nurses undertake; it is vital to understand how fatigue impacts MAEs and near misses by registered nurses working in hospital settings. 82% of the studies reviewed identified fatigue to be a contributing factor in MAEs and near misses (NMs). Policy around safe working hours need to be re-evaluated and fatigue management systems put in place to ensure delivery of safe and quality patient care.

- ❖ Darnell, D. et al (2023) '[Acute and intensive care nurses' perspectives on suicide prevention with medically hospitalized patients: Exploring barriers, facilitators, interests, and training opportunities](#)', *Journal of Advanced Nursing*, 79(9), pp. 3351-3369

This study examined opportunities for acute and intensive care nurses to engage in suicide prevention activities with patients hospitalized for medical, surgical or traumatic injury reasons. Findings suggest training in suicide prevention is important for nurses in this context and there are opportunities for nurses to engage patients in interventions beyond initial screening; however, implementation will require tailoring interventions and training to accommodate nurses' workload in the hospital context. Acute and intensive care nurses play a key role in the public health approach to suicide prevention.

- ❖ Mughal, F. et al (2023) '[New guidance for self-harm: an opportunity not to be missed](#)', British Journal of Psychiatry, pp. 1-3.

In this editorial, members of the 2022 NICE Guideline Committee highlight and discuss the key guideline recommendations (generated through evidence synthesis and consensus) for mental health professionals when caring for people after self-harm.

- ❖ Greenfield, P. (2023) '[We must confront sexual violence in the NHS to prevent further institutional harm](#)', *BMJ*, 382, pp. p2118.

Opinion piece covering the recent "Me Too in Medicine" investigation by *The BMJ* and the *Guardian*¹ examining the sheer scale of sexual violence experienced by NHS staff—35000 reports of rape, sexual assault or harassment, stalking, or abusive remarks were identified through a freedom of information request to all NHS trusts and police forces from 2017 to 2022.

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TEAMWORK

- ❖ de Quadros, D. V. et al (31/08/2023) '[Daily work variability in falls prevention of hospitalized patients: nursing team's perception](#)', *BMC Health Services Research*, 23(1), pp. 931

This study aimed to identify the variability inherent in the daily work in fall prevention, the strategies used by professionals to deal with it and the opportunities for improvement of the management of work-as-imagined. The variability occurred in the orientation of the companion and the assurance of the accompanied patient's de-ambulation. The professionals identified individual strategies to prevent falls, the importance of multi-professional work, learning with the work team, and the colleague's expertise, as well as suggesting improvements in the physical environment. This study addressed the need for fall prevention in the hospital setting as one of the main adverse events that affect patients.

- ❖ Knight, E. et al (2023) '[Interruptions in healthcare: Modelling dynamic processes and effects at a team level](#)', *Applied Ergonomics*, 112.

To understand the effects of interruptions within a dynamic environment, a computational model is developed that describes how nurses make decisions about interruptions and the effects those decisions have at a team level. Simulations reveal the interplay between urgency, task importance, the cost of being interrupted and team efficiency, depending on the consequences of clinical or procedural error, and shed light on the ways that the risks from interruptions can be better managed.

- ❖ Hose, B-Z. et al. (2023) '[Work system barriers and facilitators of a team health information technology](#)', *Applied Ergonomics*, 113, pp. 104105

This study aimed to identify work system barriers and facilitators to the use of a team health IT

that supports care transitions for paediatric trauma patients, identifying eight dimensions with both barriers and facilitators in all five work system elements: person (experience), task (task performance, workload/efficiency), technology (usability, specific features), environment (space, location), and organization (communication/coordination). Results confirm the usefulness of a continuous work system approach to technology design and implementation.

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WORK ENVIRONMENT

- ❖ Ashmore, S. and Ruthven, T. (2023) '[PSIRF Infographic - A new era in patient safety for the NHS and healthcare](#)'

Stephen Ashmore and Tracy Ruthven, Co-Directors of Clinical Audit Support Centre Limited, have created a simple, eye-catching poster to explain the new Patient Safety Incident Response Framework (PSIRF), available to download.

- ❖ Healthcare Safety Investigation Branch (2023) '[Harm caused by delays in transferring patients to the right place of care](#)'

This national investigation finds that issues relating to patient flow affect ambulance crews' ability to hand over patient care to emergency department (ED) staff. It also finds that EDs are routinely at, or exceeding, their maximum capacity and this has an impact on their ability to provide safe care.

- ❖ Imes, C. C. et al (2023) '[Wake-up Call: Night Shifts Adversely Affect Nurse Health and Retention, Patient and Public Safety, and Costs](#)', *Nursing Administration Quarterly*, 47(4), pp. E38-E53.

A mini review summarizing the findings on the impact of night shift on nurses' health and wellness, patient and public safety, and implications on organizational costs; provides strategies to promote night shift nurses' health and improve organizational costs.

- ❖ Kotagal, M. et al (2023) '[Making a move: Using simulation to identify latent safety threats before the care of injured patients in a new physical space](#)', *The Journal of Trauma and Acute Care Surgery*, 95(3), pp. 426-431

Systems-focused trauma simulations identified a large number of latent safety threats before the opening of a new critical care building. Identification of LSTs is feasible and facilitates mitigation before actual patient care begins, improving patient safety.

- ❖ Gandhi, T. K. (2023) '[How can artificial intelligence decrease cognitive and work burden for front line practitioners?](#)', *JAMIA Open*, 6(3), pp.79.

Artificial intelligence (AI) has tremendous potential to improve the cognitive and work burden of clinicians across a range of clinical activities, which could lead to reduced burnout and better clinical care. This article focuses specifically on the role AI can play in reducing cognitive and work burden, outlines the critical issues associated with the use of AI, and serves as a call to action for vendors and users to work together to develop functionality that addresses these challenges.

QUALITY IMPROVEMENT

❖ [QI Evidence Update](#) (September 2023)

❖ General Medical Council (2023) '[Good medical practice 2024](#)'

An updated version of Good Medical practice, the professional standards for all doctors in the UK, has been published. The standards have a stronger focus on behaviours and values which create respectful, fair and supportive workplaces. Good Medical Practice sets out the standards of patient care and professional behaviour expected of all doctors in the UK, across all specialties, career stages and sectors. The standards focus on behaviours and values which support good team work, make everyone feel safe to speak up, and empower doctors to provide quality care. The current version of Good Medical Practice will continue to apply to doctors on the medical register until the updated version comes into effect on 30 January 2024

❖ Thomas S. et al (2023) '[No waiting lying in a corridor: a quality improvement initiative in an emergency department](#)', *BMJ Open Quality*, 12(3), pp. e002431.

A quality improvement project with the objective of zero patients lying in bed awaiting care/referral outside a care area. Adaptation of ED organisation in the form of PDSA cycles allowed to obtain a collective team dimension to patient flow management. The PDSA strategy based on five measures allowed to remove in-house obstacles to the internal flow of patients and to fight against their installation outside the care area. These measures are easily replicable by other management teams.

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