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August 2014

Latest research from healthcare databases:

Title: Factors promoting intensive care patients' perception of feeling safe: a systematic review.

Citation: International Journal of Nursing Studies, 2014, vol./is. 51/2(261-73), 0020-7489;1873-491X

Author(s): Wassenaar A, Schouten J, Schoonhoven L

Abstract: BACKGROUND: Feeling safe in the intensive care unit is of great importance while recovering from critical illness. Moreover, feeling unsafe can result in distress. In order to meet the safety needs of intensive care patients as well as to stimulate their recovery and prevent distress, nurses must be aware of factors promoting patients' perception of feeling safe during an intensive care admission. To our knowledge, there is no synthesis of these factors available as yet.OBJECTIVE: To systematically describe the factors that promote patients' perception of feeling safe in an intensive care unit.DESIGN: A systematic review of qualitative and quantitative studies.DATA SOURCES: PubMed, Embase, CINAHL, and PsycINFO were searched up to March 2012.REVIEW METHODS: Methodological quality was assessed by two authors using the QualSyst tool. Data from the included studies were extracted into a customised data extraction form.RESULTS: The initial search resulted in 1326 records. Ultimately, eleven studies were relevant to the research question and included in the review. No studies needed to be excluded because of low quality scores. Analysis of the factors in these studies resulted in four overarching themes that promote intensive care patients' perception of feeling safe. These themes were: nursing care, patients' issues, relatives, and technological support. Nursing care was described most frequently as an important factor promoting patients' feeling of safety in an intensive care unit. Relatives were the link between intensive care patients and staff.CONCLUSIONS: Nurses can increase the perception of feeling safe in critically ill patients by taking into account the promoting factors described in this review. By being aware of these factors nurses can improve quality of care in their intensive care unit.

Publication Type: Journal Article, Review

Source: MEDLINE

Title: Supply chain, information systems play important role in patient safety.

Citation: Biomedical Instrumentation & Technology, May 2014, vol./is. 48/3(191-3), 0899-8205;0899-8205 (2014 May-Jun)

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Author(s): Miceli C

Publication Type: Interview

Source: MEDLINE

Title: Swab and instrument count practice: ways to enhance patient safety.

Citation: British Journal of Nursing, June 2014, vol./is. 23/11(590-3), 0966-0461;0966-0461 (2014 Jun 12-25)

Author(s): Smith Y, Burke L

Abstract: This article presents the results of an audit of swab and instrument count practices in the operating department of a large hospital NHS Trust in South East England. A literature review of the subject is presented followed by the methodology used including questionnaires and observation of practice. Findings are discussed in terms of compliance with the department's swab and instrument count policy and observed practice mapped against the recommendations for best practice in the literature. The findings show that audit of practice is still treated with suspicion by many and that a number of practices of scrub and circulating personnel in operating theatres need to be improved. Recommendations are made related to improving staff development in the department and introducing clinical supervision as one way to provide support for colleagues to reflect on their practice and change to more evidence-based practices in the operating department.

Publication Type: Journal Article

Source: MEDLINE

Full Text:

Available from *British journal of nursing* in Rotherham FT Library & Knowledge Service

Available from *EBSCOhost* in British Journal of Nursing

Title: An analysis of patient safety incidents associated with medications reported from critical care units in the North West of England between 2009 and 2012.

Citation: Anaesthesia, July 2014, vol./is. 69/7(735-45), 0003-2409;1365-2044 (2014 Jul)

Author(s): Thomas AN, Taylor RJ

Abstract: Incident reporting is promoted as a key tool for improving patient safety in healthcare. We analysed 2238 patient safety incidents involving medications submitted from up to 29 critical care units each year in the North West of England between 2009 and 2012; 452 (20%) of these incidents led to harm

to patients. Although 1461 (65%) incidents were identified as having the potential to be preventable, there was no reduction in the rate of incidents per 1000 days between 2009 and 2012 (5.9 in 2009, 6.6 in 2012).

Furthermore, in the 2012 data, there were wide variations in the incident rates between units, the median (IQR [range]) rate per 1000 patient days for individual units being 6.8 (3.8-11.0 [1.3-37.1]). The variation in the percentage that could have been avoided was narrower, with a median (IQR [range]) of 70% (61-80% [38-100%]). The most commonly reported drugs were noradrenaline (161 incidents, 92 with harm), heparins (153 incidents, 29 with harm), morphine (131 incidents, 14 with harm) and insulin (111 incidents, 54 with harm). The administration of drugs was the stage in the process where incidents were most commonly reported; it was also the stage most likely to harm patients. We conclude that the wide range in reported rates between units, and the scope for preventing many incidents, suggest that quality improvement initiatives could improve medication safety in the units studied. 2014 The Association of Anaesthetists of Great Britain and Ireland.

Publication Type: Journal Article

Source: MEDLINE

Full Text: Available from *Anaesthesia* in Rotherham FT Library & Knowledge Service

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Title: The effects of safety checklists in medicine: a systematic review.

Citation: Acta Anaesthesiologica Scandinavica, January 2014, vol./is. 58/1(5-18), 0001-5172;1399-6576 (2014 Jan)

Author(s): Thomassen O, Storesund A, Softeland E, Brattebo G

Abstract: BACKGROUND: Safety checklists have become an established safety tool in medicine. Despite studies showing decreased mortality and complications, the effects and feasibility of checklists have been questioned. This systematic review summarises the medical literature aiming to show the effects of safety checklists with a number of outcomes.METHODS: The Preferred Reporting Items for Systematic Review and Meta-Analysis (PRISMA) statement was used. All studies in which safety checklists were used as an additional tool designed to assure that an operation or task was performed as planned were included.RESULTS: The initial search extracted 7408 hits. Twenty-nine articles met the inclusion criteria. Five additional studies were identified by a cross-referencing search. Four groups were made according to outcome measures. One group (n=7) had 'hard' outcome measures, such as mortality and morbidity. The remaining studies, reporting 'softer' process-related measures, were divided into three categories: adherence to guidelines (n=6), human factors (n=16), and reduction of adverse events (n=5). The main findings were improved communication, reduced adverse events, better adherence to standard operating procedures, and reduced morbidity and mortality. None of the included studies reported decreased patient safety or quality after introducing safety checklists.CONCLUSION: Safety checklists appear to be effective tools for improving patient safety in various clinical settings by strengthening compliance with guidelines, improving human factors, reducing the incidence of adverse events, and decreasing mortality and

morbidity. None of the included studies met NHS quality criteria. Effects on safety. 2013 The Acta Anaesthesiologica Scandinavica Foundation. Published by John Wiley & Sons Ltd.

Publication Type: Journal Article, Meta-Analysis, Research Support, Non-U.S. Gov't, Review

Source: MEDLINE

Title: Leadership walkrounds in mental health care.

Citation: Nursing Times, June 2014, vol./is. 110/23(21-3), 0954-7762;0954-7762 (2014 Jun 4-10)

Author(s): Ashton S

Abstract: Patient safety leadership walkrounds are designed to assist healthcare leaders to improve patient safety. At 2gether Foundation Trust, walkrounds have been developed in mental health settings. They ensure that executives are informed firsthand about the safety concerns of frontline staff, while ensuring staff are listened to and supported when issues of safety are raised. Patient safety and quality improvements have been implemented over time through this process.

Publication Type: Journal Article

Source: MEDLINE

Title: "Failing to invest in the nursing workforce puts patients at risk".

Citation: Nursing Times, June 2014, vol./is. 110/23(7), 0954-7762;0954-7762 (2014 Jun 4-10)

Author(s): Rafferty AM, Griffiths P

Publication Type: Journal Article

Source: MEDLINE

Title: "Technology can give nurses a voice for safer staffing levels".

Citation: Nursing Times, June 2014, vol./is. 110/24(7), 0954-7762;0954-7762 (2014 Jun 11-17)

Author(s): Jessop S

Publication Type: Journal Article

Source: MEDLINE

Full Text: Available from *KS Local Holdings* in Nursing Times

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Title: "Safe staffing a priority but NMC stays hobbled".

Citation: Nursing Times, June 2014, vol./is. 110/24(1), 0954-7762;0954-7762 (2014 Jun 11-17)

Author(s): Middleton J

Publication Type: Editorial

Source: MEDLINE

Full Text:

Title: Safety measurement and monitoring in healthcare: A framework to guide clinical teams and healthcare organisations in maintaining safety

Citation: BMJ Quality and Safety, August 2014, vol./is. 23/8(670-677), 2044-5415 (August 2014)

Author(s): Vincent C., Burnett S., Carthey J.

Abstract: Patients, clinicians and managers all want to be reassured that their healthcare organisation is safe. But there is no consensus about what we mean when we ask whether a healthcare organisation is safe or how this is achieved. In the UK, the measurement of harm, so important in the evolution of patient safety, has been neglected in favour of incident reporting. The use of softer intelligence for monitoring and anticipation of problems receives little mention in official policy. The Francis Inquiry report into patient treatment at the Mid Staffordshire NHS Foundation Trust set out 29 recommendations on measurement, more than on any other topic, and set the measurement of safety an absolute priority for healthcare organisations. The Berwick review found that most healthcare organisations at present have very little capacity to analyse, monitor or learn from safety and quality information. This paper summarises the findings of a more extensive report and proposes a framework which can guide clinical teams and healthcare organisations in the measurement and monitoring of safety and in reviewing progress against safety objectives. The framework has been used so far to promote self-reflection at both board and clinical team level, to stimulate an organisational check or analysis in the gaps of information and to promote discussion of 'what could we do differently'.

Publication Type: Journal: Review

Source: EMBASE

Title: Why has the safety and quality movement been slow to improve care?

Citation: International Journal of Clinical Practice, August 2014, vol./is. 68/8(932-935), 1368-5031;1742-1241 (August 2014)

Author(s): Phelps G., Barach P.

Abstract: Buist and Middleton lament that the safety and quality 'agenda' has failed to fundamentally alter the safety of healthcare systems, in part because of the disengagement of doctors from their responsibilities for patient safety. While there have been discernable improvements in the efficiency and effectiveness of care in some settings, patients still experience unacceptable harm and often struggle to have their voices heard; processes are not as efficient as they could be; and costs continue to rise at alarming rates while quality issues remain. Perhaps of most concern, recent public reports into health system failures continue to document a widespread lack of attentiveness to patient concerns, a culture of denial and widespread lack of professionalism. Alarmingly, clinician discontentment, cynicism and burn-out are reflected in antagonistic language by clinicians about the healthcare system and their patients. Taken together with the many dissatisfied and now more vocal

patient harm, a point to an unsustainable crisis affecting other healthcare systems which has been getting worse over past decade. This personal perspective aims to address the fundamental

tensions that are keeping much of healthcare reform efforts from successfully transforming the culture and outcomes except at the margins. 2014 John Wiley & Sons Ltd.

Publication Type: Journal: Review

Source: EMBASE

Title: Warfarin patient safety: Free analysis tool for GP practices

Citation: Prescriber, July 2014, vol./is. 25/13-16(33-34), 0959-6682;1931-2253 (July/August 2014)

Author(s): Robinson J., Oliver K.

Abstract: The authors describe how the freely available Warfarin Patient Safety audit tool can help GP practices manage their warfarin patients more safely and effectively. 2014 Wiley Interface Ltd.

Publication Type: Journal: Article

Source: EMBASE

Title: Sustaining a Culture of Safety: Are We One Step Forward or Three Steps Back?

Citation: AORN Journal, December 2013, vol./is. 98/6(634-646), 0001-2092 (December 2013)

Author(s): Guglielmi C.L., Graling P., Paige J.T., Cammarata B.J., Lopez C., Groah L.K.

Publication Type: Journal: Article

Source: EMBASE

Full Text:

Available from *EBSCOhost* in AORN Journal

Available from *ProQuest* in Association of Operating Room Nurses. AORN Journal

Available from *ProQuest* in Association of Operating Room Nurses. AORN Journal

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Title: Patient safety and quality care

Author(s): Nelson K.

Publication Type: Journal: Article

Source: EMBASE

Title: A care bundle approach to falls prevention

Citation: Nursing Times, May 2014, vol./is. 110/20(21-23), 0954-7762 (14 May 2014)

Author(s): Sutton D., Windsor J., Husk J.

Abstract: Falls cause harm and distress to NHS inpatients every year. One hospital's implementation of a regional FallSafe project has increased the use of evidence- based measures to prevent falls. The project relied on a network of falls champions, who were nurses or healthcare assistants who taught and inspired their colleagues to implement care bundles.

Publication Type: Trade Journal: Article

Source: EMBASE

Full Text:

Title: Safeguarding adults

Citation: Journal of perioperative practice, May 2014, vol./is. 24/5(118-120), 1750-4589 (May 2014)

Author(s): Richardson V.

Abstract: The safeguarding of patients is a key concern for all health and care professionals. Research shows that more instances of unacceptable care are likely to occur due to an increase in population of those deemed to be vulnerable. Increasing professionals' awareness, knowledge and understanding of safeguarding and of the systems in place for reporting concerns is essential for best practice and for protecting patients and their families.

Title: Teamwork and communication: an effective approach to patient safety

Citation: World hospitals and health services : the official journal of the International Hospital Federation, 2014, vol./is. 50/1(19-22), 1029-0540 (2014)

Author(s): Mujumdar S., Santos D.

Abstract: Teamwork and communication failures are leading causes of patient safety incidents in health care. Though health care providers must work in teams, they are not well-trained in teamwork and communication skills. Health care faces the problems of differences in communication styles, communication failures and poor teamwork. There is enough evidence in the literature to show that communication failure is detrimental to patient safety. It is estimated that 80% of serious medical errors worldwide take place because of miscommunication between medical providers. NUH recognizes that effective communication and teamwork are essential in the delivery of high quality safe patient care, especially in a complex organization. NUH is a good example, where there is a rich mix of nationalities and races, in staff and in patients, and there is a rapidly expanding care environment. NUH had to overcome these challenges by adopting a multi-pronged approach. The trials and tribulations of NUH in this journey were worthwhile as the patient safety climate survey scores improved over the years.

Publication Type: Journal: Article

Source: EMBASE

Title: Patient-Safety-Related Hospital Deaths in England: Thematic Analysis of Incidents Reported to a National Database, 2010-2012

Citation: PLoS Medicine, June 2014, vol./is. 11/6(1-8), 1549-1277;1549-1676 (June 2014)

Author(s): Donaldson L.J., Panesar S.S., Darzi A.

Language: English

Abstract: Background:Hospital mortality is increasingly being regarded as a key indicator of patient safety, yet methodologies for assessing mortality are frequently contested and seldom point directly to areas of risk and solutions. The aim of our study was to classify reports of deaths due to unsafe care into broad areas of systemic failure capable of being addressed by stronger policies, procedures, and

practices. The database was queried to analyse patient safety incident reporting system after mandatory reporting of such incidents was introduced.Methods and Findings:The UK National Health Service database was searched for incidents resulting in a reported death of an adult over the period of the study. The study population comprised 2,010 incidents involving patients aged 16 y and over in acute hospital settings. Each incident report was reviewed by two of the authors, and, by scrutinising the structured information together with the free text, a main reason for the harm was identified and recorded as one of 18 incident types. These incident types were then aggregated into six areas of apparent systemic failure: mismanagement of deterioration (35%), failure of prevention (26%), deficient checking and oversight (11%), dysfunctional patient flow (10%), equipment-related errors (6%), and other (12%). The most common incident types were failure to act on or recognise deterioration (23%), inpatient falls (10%), healthcare-associated infections (10%), unexpected per-operative death (6%), and poor or inadequate handover (5%). Analysis of these 2,010 fatal incidents reveals patterns of issues that point to actionable areas for improvement.Conclusions:Our approach demonstrates the potential utility of patient safety incident reports in identifying areas of service failure and highlights opportunities for corrective action to save lives.Please see later in the article for the Editors' Summary. 2014 Donaldson et al.

Publication Type: Journal: Review

Source: EMBASE

Full Text: Available from *National Library of Medicine* in PLoS Medicine

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Title: Feeling safe during an inpatient hospitalization: a concept analysis

Citation: Journal of Advanced Nursing, Aug 2014, vol. 70, no. 8, p. 1727-1737, 0309-2402 (August 2014)

Author(s): Mollon, Deene

Abstract: Aim. This paper aims to explore the critical attributes of the concept feeling safe. Background. The safe delivery of care is a high priority; however; it is not really known what it means to the patient to 'feel safe' during an inpatient hospitalization. This analysis explores the topic of safety from the patient's perspective. Design. Concept analysis. Data sources. The data bases of CINAHL, Medline, PsychInfo and Google Scholar for the years 1995-2012 were searched using the terms safe and feeling safe. Methods. The eight-step concept analysis method of Walker and Avant was used to analyse the concept of feeling safe. Uses and defining attributes, as well as identified antecedents, consequences and empirical referents, are presented. Case examples are provided to assist in the understanding of defining attributes. Results. Feeling safe is defined as an emotional state where perceptions of care contribute to a sense of security and freedom from harm. Four attributes were identified: trust, cared for, presence and knowledge. Relationship, environment and suffering are the antecedents of feeling safe, while control, hope and relaxed or calm are the consequences. Empirical referents and early development of a theory of feeling safe are explored. Conclusion. This analysis begins the work of synthesizing qualitative research already completed around the concept of feeling safe by defining the key attributes of the concept. Support for the importance of

developing patient centred models of care and creating positive environments where patients receive high-quality care and feel safe is provided. [PUBLICATION] 58 references

Source: BNI

Full Text: Available from *Journal of advanced nursing* in Rotherham FT Library & Knowledge Service

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Online resources:

NHS Improving Quality Patient Safety Programme
http://www.nhsiq.nhs.uk/improvement-programmes/patient-safety.aspx

Patient Safety (NHS England Website)
http://www.england.nhs.uk/ourwork/patientsafety/

Patient Safety (Health Foundation Website)
http://www.health.org.uk/areas-of-work/topics/patient-safety/

Patient safety resource centre
http://patientsafety.health.org.uk/

National Patient Safety Agency
http://www.npsa.nhs.uk/

Reporting Patient Safety issues
http://www.nrls.npsa.nhs.uk/

Patient Safety 1st
http://www.patientsafetyfirst.nhs.uk/content.aspx?path=/

National Patient Safety Alerting System
http://www.england.nhs.uk/ourwork/patientsafety/psa/national-psa-system/

An introduction to the NHS England National Patient Safety Alerting System
http://www.england.nhs.uk/wp-content/uploads/2014/01/npsas-guide.pdf