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Patient safety: May 2014

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

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Research reports

Getting to grips with human factors - strategic actions for safer care. A learning resource for boards

This guide provides boards, non-executives and senior leaders with a strategic view of the importance of human factors approaches to improving patient safety.
It reviews the central principles of human factors including teamwork, culture, workplace design and individual behaviour, and provides examples and guidance on how boards can model and support the application of human factors knowledge to patient safety in their organisations.

Safer care - Stepwise Falls Guide

Produced by the NHS Institute for Innovation and Improvement, this is a practical step by step guide and toolkit to reducing inpatient falls for ward staff and frontline healthcare clinical teams. It will be useful to all healthcare teams looking after inpatients with risk of falls.

Making our health and care systems fit for an ageing population

This report from The Kings Fund authored by David Oliver, Catherine Foot, and Richard Humphries describes some of the problems with systems of care for frailer older people and sets out a framework and tools to help local service leaders improve the care they provide for older people.

FRAILsafe: A safety checklist for frail older patients entering acute hospital care

This project, supported by the Health Foundation and led by Sheffield Teaching Hospitals NHS Foundation Trust on behalf of British Geriatrics Society, focuses on a series of measurable harms posing a risk to older patients, including confusion, falls, and adverse drug reactions.

CQC - Our new approach to the inspection of NHS acute hospitals

This report provides a review of the new approach to acute hospital inspections taken by the Care Quality Commission in England.

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Building a culture of candour

This document presents the final report of a review into the need for a duty of candour in healthcare organisations and to be honest with patients when they have been harmed during their care.
The review specifically examines the threshold for the duty of candour and the various incentives that might be used to ensure that care organisations are candid after harmful adverse events. The report makes three recommendations regarding the need for a duty of candour in all cases of 'significant harm' to patients, and emphasises the broader need for organisations to develop a culture of candour.

What we know about how to improve quality and safety in hospitals

In this narrated slideshow, Professor Mary Dixon-Woods looks at improving the quality and safety of care in hospitals, and suggests that we need to take a three-pronged approach: ensuring we are collecting the right data and interpreting it intelligently, looking at the systems we work in and finally how culture and behaviour impact on quality of care.

Patient safety in anaesthesiology: a starter kit

The European Society of Anaesthsiology website provides a range of guidance, tools, presentations, alerts and documents relating to patient safety issues in anaesthesia.

Staff Care: How to engage staff in the NHS and why it matters

Engaging with staff is an essential element of patient safety. All staff need to feel listened to, involved in decisions and in control of their work - and this is particularly important for managing and improving patient safety.
This guide from the Point of Care Foundation provides a useful synthesis of the key evidence that demonstrates the importance of engaging with staff, and lays out a range of practical advice for how staff can be better engaged, supported and listened to.

Journal articles

Title: Patient Safety Incidents in Home Hospice Care: The Experiences of Hospice Interdisciplinary Team Members.

Citation: Journal of Palliative Medicine, 01 May 2014, vol./is. 17/5(540-544), 10966218

Author(s): Smucker, Douglas R., Regan, Saundra, Elder, Nancy C., Gerrety, Erica

Language: English

Abstract: Background: Hospice provides a full range of services for patients near the end of life, often in the patient's own home. There are no published studies that describe patient safety incidents in home hospice care. Objective: The study objective was to explore the types and characteristics of patient safety incidents in home hospice care from the experiences of hospice interdisciplinary team members. Methods: The study design is qualitative and descriptive. From a convenience sample of 17 hospices in 13 states we identified 62 participants including hospice nurses, physicians, social workers, chaplains, and home health aides. We interviewed a separate sample of 19 experienced hospice leaders to assess the credibility of primary results. Semistructured telephone interviews were recorded and transcribed. Four researchers used an editing technique to identify common themes from the interviews. Results: Major themes suggested a definition of patient safety in home hospice that includes concern for unnecessary harm to family caregivers or unnecessary disruption of the natural dying process. The most commonly described categories of patient harm were injuries from falls and inadequate control of symptoms. The most commonly cited contributing factors were related to patients, family caregivers, or the home setting. Few participants recalled incidents or harm related to medical errors by hospice team members. Conclusions: This is the first study to describe patient safety incidents from the experiences of hospice interdisciplinary team members. Compared with patient safety studies from other health care settings, participants recalled few incidents related to errors in evaluation, treatment, or communication by the hospice team.

Publication Type: journal article

Source: CINAHL

Title: Safe Patient Handling and Movement: A Literature Review.

Citation: Rehabilitation Nursing, 01 May 2014, vol./is. 39/3(123-129), 02784807

Author(s): Mayeda-Letourneau, Janet

Language: English

Abstract: Purpose Musculoskeletal disorders (MSD) as a result of patient handling tasks occur at high rates for nursing staff and other patient care providers. Patient care providers perform high-risk patient handling tasks including lifting, transferring, ambulating, and repositioning patients. Continuous performance of these tasks places a patient care provider at risk for development of a MSD. MSDs affect a healthcare organization financially and impact the core of a hospital-the health of the workforce. The purpose of this research was to study the impact of a safe patient handling and movement program on healthcare worker injury, costs and job satisfaction. Methods A critical review of the safe patient handling literature was conducted. Findings A safe patient handling and movement (SPHM) program decreases overall work injury costs and improves healthcare worker job satisfaction. Conclusions and Clinical Relevance Reduced work injuries, decreased injury costs, improved patient outcomes validated in research and employees feeling the support of their employer all contribute to a program that moves an organization toward a culture of safety.

Publication Type: journal article

Source: CINAHL

Title: Putting the patient's interests first in the NHS.

Citation: British Journal of Nursing, 24 April 2014, vol./is. 23/8(436-437), 09660461

Author(s): Tingle, John

Language: English

Publication Type: journal article

Source: CINAHL

Full Text:
Available from *British journal of nursing* in Rotherham FT Library & Knowledge Service
Available from *EBSCOhost* in British Journal of Nursing

Title: "Staffing guidance falls short for patient safety".

Citation: Nursing Times, 09 April 2014, vol./is. 110/15(1-1), 09547762

Author(s): Middleton, Jenni

Language: English

Publication Type: journal article

Source: CINAHL

Full Text: Available from *Nursing times* in Rotherham FT Library & Knowledge Service
Available from *ProQuest* in Nursing Times
Available from *ProQuest* in Nursing Times

Title: Bullying: A Hidden Threat To Patient Safety.

Citation: Nephrology Nursing Journal, 01 March 2014, vol./is. 41/2(193-200), 1526744X

Author(s): Longo, Joy, Hain, Debra

Language: English

Abstract: Patient safety is a crucial element for quality care in hemodialysis facilities. When evaluating possible threats to safety, an important factor to consider is the behavior of the healthcare staff. Inappropriate behaviors, such as bullying, have been associated with poor clinical outcomes. In addressing inappropriate behaviors, it is necessary to consider the role of the work environment. Healthy work environment initiatives provide a possible strategy to prevent and/or address the behaviors.

Publication Type: journal article

Source: CINAHL

Full Text:
Available from *EBSCOhost* in Nephrology Nursing Journal
Available from *ProQuest* in Nephrology Nursing Journal
Available from *ProQuest* in Nephrology Nursing Journal

Title: Improving Patient Safety by Improving Water Quality: A CQI Project Aimed at Reducing Positive Dialysate and Endotoxin Culture Rates.

Citation: Nephrology Nursing Journal, 01 March 2014, vol./is. 41/2(207-207), 1526744X

Author(s): Ryan, E. James

Language: English

Publication Type: journal article

Source: CINAHL

Full Text:
Available from *EBSCOhost* in Nephrology Nursing Journal
Available from *ProQuest* in Nephrology Nursing Journal
Available from *ProQuest* in Nephrology Nursing Journal

Title: Adverse incidents and patient safety - improving the learning experience of junior doctors.

Citation: Clinical Medicine, February 2014, vol./is. 14/1(42-3), 1470-2118;1470-2118 (2014 Feb)

Author(s): Baruch N

Language: English

Abstract: The need to ensure patient safety in the National Health Service (NHS) is a national priority. However, it has long been recognised that a culture of blame impedes learning from previous adverse incidents. It is important to feedback the outcomes of investigations into incidents to NHS staff, but junior doctors have little knowledge of learning points from investigations into adverse incidents. Learning from past mistakes would improve practice and the level of care provided by junior doctors. A forum for learning from mistakes could also provide an opportunity to review past incidents in an open and supportive environment. This could, in turn, start to change the current culture of blame in the NHS and contribute to higher standards of patient safety in the future.

Publication Type: Journal Article

Source: MEDLINE

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

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Title: How studying human factors improves patient safety.

Citation: Canadian Nurse, March 2014, vol./is. 110/2(25-9), 0008-4581;0008-4581 (2014 Mar)

Author(s): Eggertson L

Language: English

Publication Type: Journal Article

Source: MEDLINE

Full Text:
Available from *EBSCOhost* in Canadian Nurse
Available from *EBSCOhost* in Canadian Nurse

Title: Safeguarding. Staying safe in an age of austerity.

Citation: Health Service Journal, December 2013, vol./is. Suppl/(6-7), 0952-2271;0952-2271 (2013 Dec 6)

Author(s): Moore A

Language: English

Publication Type: Journal Article

Source: MEDLINE

Full Text:
Available from *ProQuest* in Health Service Journal, The
Available from *ProQuest* in Health Service Journal, The

Title: Clinical supervisors: are they the key to making care safer?.

Citation: BMJ Quality & Safety, August 2013, vol./is. 22/8(609-12), 2044-5415;2044-5423 (2013 Aug)

Author(s): Walton M, Barraclough B

Language: English

Abstract: The evidence shows that notwithstanding efforts by health professionals and hospital managers to improve the quality and safety of healthcare, adverse events remain prevalent. Clinical supervision is understandably dominated by transferring discipline knowledge and skills but the environment today requires equal attention to integrating patient safety concepts and principles into clinical supervision. Trainees learn from supervisors who themselves often have inadequate patient safety knowledge and skills. This conundrum may partly explain why there has been no visible reduction in adverse events. Patient safety literature has emphasised that clinical errors are rarely linked with incompetent doctors or trainees with inadequate knowledge but rather to failures in appreciating the context, complexity and uncertainty of clinical decisions made under the pressure of time. It is time to consider whether clinical supervisors themselves first need to demonstrate patient safety competencies before being responsible for supervising trainees.

Publication Type: Editorial

Source: MEDLINE

Title: Building capacity and capability for patient safety education: a train-the-trainers programme for senior doctors.

Citation: BMJ Quality & Safety, August 2013, vol./is. 22/8(618-25), 2044-5415;2044-5423 (2013 Aug)

Author(s): Ahmed M, Arora S, Baker P, Hayden J, Vincent C, Sevdalis N

Language: English

Abstract: OBJECTIVES: To develop, implement and evaluate a training programme for senior doctors to become faculty leaders for patient safety training.METHODS: Senior doctors were recruited from across 20 hospitals in the North Western Deanery, England, UK. The intervention comprised a half-day course in patient safety theory, root cause analysis and small-group facilitation, following which

participants were invited to sign up as faculty for a region-wide patient safety training programme for trainees 'Lessons Learnt'. Course evaluation comprised a prospective longitudinal study conducted in 2010-2012. Patient safety knowledge, attitudes and skills were evaluated pre and post course and retention further evaluated 8 months post course.RESULTS: 216 senior doctors volunteered as faculty of whom 122 were appointed. Participants reported high levels of satisfaction with the course. Objective scores of patient safety knowledge significantly improved immediately post course (MedianPre course=70%, MedianPost course=80%, $p<0.001$) and were sustained at 8 months (Median8 month post course=90%). Similarly, measures of attitudes and self-reported safety skills also significantly improved post course and were sustained. Upon completion of the course, 88/122 (72%) participants facilitated 213 'Lessons Learnt' sessions from January 2011 to July 2012 (mean 2, range 1-8 sessions per faculty member). Trainee satisfaction with faculty was high.CONCLUSIONS: There is considerable appetite for senior doctors to engage with training in patient safety as teachers and learners. Training senior doctors in patient safety is feasible, acceptable and effective as a means of building capacity and capability for delivering training in this rapidly emerging field.

Publication Type: Evaluation Studies, Journal Article, Research Support, Non-U.S. Gov't

Source: MEDLINE

Title: Retrofitting hospitals for obese patients. Hospitals balance safety, costs in equipping facilities for bariatric care.

Citation: Modern Healthcare, February 2014, vol./is. 44/6(16-7), 0160-7480;0160-7480 (2014 Feb 10)
Author(s): Rice S

Language: English

Publication Type: Journal Article

Source: MEDLINE

Full Text:
Available from *EBSCOhost* in Modern Healthcare
Available from *ProQuest* in Modern Healthcare
Available from *EBSCOhost* in Modern Healthcare

Title: Patient safety resources on the web.

Citation: Nephrology Nursing Journal: Journal of the American Nephrology Nurses' Association, January 2014, vol./is. 41/1(97-9), 1526-744X;1526-744X (2014 Jan-Feb)

Author(s): Brooks DH

Language: English

Publication Type: Journal Article

Source: MEDLINE

Full Text:
Available from *EBSCOhost* in Nephrology Nursing Journal

Title: Implementing the Safety Thermometer tool in one NHS trust.

Citation: British Journal of Nursing, March 2014, vol./is. 23/5(268-72), 0966-0461;0966-0461 (2014 Mar 13-26)

Author(s): Buckley C, Cooney K, Sills E, Sullivan E

Language: English

Abstract: To address measurement of patient safety, the NHS in England has introduced the NHS Safety Thermometer using the Commissioning for Quality and Innovation (CQUIN) scheme. The scheme offers a financial reward to all providers of NHS care measuring four common harms using the NHS Safety Thermometer on one day each month, with further incentives to achieve improvement goals in subsequent years of the scheme. This article discusses the background to the scheme and a rationale for the focus on pressure ulcers, falls in care, catheter use and urinary tract infection, and venous thromboembolism. The implementation process for this scheme in a large NHS foundation trust is detailed together with its effect within the authors' organisation on harm-free care for their patients.

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: Safety in surgery and overall health: What is the responsibility of the patient?

Citation: Clinical Orthopaedics and Related Research, May 2014, vol./is. 472/5(1373-1374), 0009-921X;1528-1132 (May 2014)

Author(s): Lee M.J.

Language: English

Publication Type: Journal: Article

Source: EMBASE

Full Text:
Available from *Clinical orthopaedics and related research* in Rotherham FT Library & Knowledge Service
Available from *Springer NHS* in Clinical Orthopaedics and Related Research
Available from *EBSCOhost EJS* in Clinical Orthopaedics and Related Research

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Title: Patient safety at home

Citation: British journal of community nursing, February 2014, vol./is. 19/2(102), 1462-4753 (Feb 2014)

Author(s): While A.

Language: English

Publication Type: Journal: Article

Source: EMBASE

Full Text:
Available from *EBSCOhost* in British Journal of Community Nursing

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Title: NHS England learns lessons from Scottish colleagues on improving patient safety

Citation: Nursing management (Harrow, London, England : 1994), March 2014, vol./is. 20/10(12-13), 1354-5760 (Mar 2014)

Author(s): Trueland J.

Language: English

Publication Type: Journal: Article

Source: EMBASE

Full Text:
Available from *EBSCOhost* in Nursing Management - UK

Title: Concerns about care in NHS maternity services

Citation: British journal of nursing (Mark Allen Publishing), February 2014, vol./is. 23/3(180-181), 0966-0461 (2014 Feb 13-26)

Author(s): Tingle J.

Language: English

Publication Type: Journal: Article

Source: EMBASE

Full Text:
Available from *British journal of nursing* in Rotherham FT Library & Knowledge Service
Available from *EBSCOhost* in British Journal of Nursing

Title: Identification of an updated set of prescribing-safety indicators for GPs

Citation: British Journal of General Practice, April 2014, vol./is. 64/621(e181-e190), 0960-1643 (01 Apr 2014)

Author(s): Spencer R., Bell B., Avery A.J., Gookey G., Campbell S.M.

Language: English

Abstract: Background: Medication error is an important contributor to patient morbidity and mortality and is associated with inadequate patient safety measures. However, prescribing-safety tools specifically designed for use in general practice are lacking. Aim: To identify and update a set of prescribingsafety indicators for assessing the safety of prescribing in general practice, and to estimate the risk of harm to patients associated with each indicator. Design and setting: RAND/UCLA consensus development of indicators in UK general practice. Method: Prescribing indicators were identified from a systematic review and previous consensus exercise. The RAND Appropriateness Method was used to further identify and develop the indicators with an electronic-Delphi method used to rate the risk associated with them. Twelve GPs from all the countries of the UK participated in the RAND exercise, with 11 GPs rating risk using the electronic-Delphi approach. Results: Fifty-six prescribing-safety indicators were considered appropriate for inclusion (overall panel median rating of 7-9, with agreement). These indicators cover hazardous prescribing across a range of therapeutic indications, hazardous drug-drug combinations and inadequate laboratory test monitoring. Twentythree (41%) of these indicators were considered high risk or extreme risk by 80% or more of the participants. Conclusion: This study identified a set of 56 indicators that were considered, by a panel of GPs, to be appropriate for assessing the safety of GP prescribing. Twenty-three of these indicators were considered to be associated with high or extreme risk to patients and should be the focus of efforts to improve patient safety. British Journal of General Practice.

Publication Type: Journal: Article

Source: EMBASE

Title: Patient safety and general practice: Traversing the tightrope

Citation: British Journal of General Practice, April 2014, vol./is. 64/621(164-165), 0960-1643 (01 Apr 2014)

Author(s): De Wet C., Bowie P.

Language: English

Publication Type: Journal: Editorial

Source: EMBASE

Title: Patient safety

Citation: Nursing standard (Royal College of Nursing (Great Britain) : 1987), February 2014, vol./is. 28/25(54), 0029-6570 (2014 Feb 19-25)

Author(s): Young L.

Language: English

Publication Type: : Article

Source: EMBASE

Full Text:
Available from *EBSCOhost* in Nursing Standard

Title: Berwick patient safety team: Making the NHS a safer place

Citation: BMJ (Online), March 2014, vol./is. 348/, 1756-1833 (28 Mar 2014)

Author(s): Gulland A.

Language: English

Publication Type: Journal: Article

Source: EMBASE

Title: The use of global positioning systems in promoting safer walking for people with dementia

Citation: Journal of Telemedicine and Telecare, 2013, vol./is. 19/5(288-292), 1357-633X;1758-1109 (2013)

Author(s): McKinstry B., Sheikh A.

Language: English

Abstract: There are about 5 million people in Europe who have dementia, approximately half of whom need daily care. A common reason why dementia sufferers are admitted to long-term care is because of "wandering", i.e. leaving home without informing a carer, thereby potentially putting themselves at risk. Common methods of managing wandering include locking doors or alerting carers when a door is opened. A new method of managing wandering is by using electronic location devices. These depend on the satellite-based global positioning system (GPS). People can wear a
location device in the form of a watch or pendant, or carry it like a mobile phone. This offers affected individuals the possibility of safe walking, with the reassurance that they can be found quickly if lost. However, it is not known how effective this method is and its use raises questions about safety and individual civil liberties. GPS location is a potentially useful method of managing wandering in dementia and there is considerable pressure on caregivers from commercial organisations to adopt the technique.

Research is therefore required to determine which people are best suited for such devices, how effective they are in practice and what effect they have on important outcomes.

Publication Type: : Article

Source: EMBASE

Full Text:
Available from *EBSCOhost* in Journal of Telemedicine & Telecare

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Title: Health and safety in the NHS

Citation: British journal of nursing (Mark Allen Publishing), January 2014, vol./is. 23/2(112-113), 0966-0461 (2014 Jan 23-Feb 12)

Author(s): Griffith R.

Language: English

Abstract: Accidents at work cost the NHS some billion pounds every year. Over half of these accidents are due to avoidable slips and falls-the most common cause of claim for compensation faced by the NHS. Under the Management of Health and Safety at Work Regulations 1999, the NHS as an employer and nurses as employees have a legal obligation to manage health and safety and to ensure that others are not put at risk by work-related activities. The first of a series, this article on health and safety law sets out the duties imposed on NHS organisations and their employees.

Publication Type: : Article

Source: EMBASE

Full Text:
Available from *British journal of nursing* in Rotherham FT Library & Knowledge Service
Available from *EBSCOhost* in British Journal of Nursing

Title: CQC develops new criteria for quality and safety of care

Citation: British journal of nursing (Mark Allen Publishing), January 2014, vol./is. 23/2(110-111), 0966-0461 (2014 Jan 23-Feb 12)

Author(s): Glasper A.

Language: English

Publication Type: : Article

Source: EMBASE

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Full Text:
Available from *British journal of nursing* in Rotherham FT Library & Knowledge Service
Available from *EBSCOhost* in British Journal of Nursing

Title: Implementing the Berwick Report in general practice

Citation: Quality in primary care, 2013, vol./is. 21/6(333-337), 1479-1072 (2013)

Author(s): Dawda P., Russell L.

Language: English

Publication Type: : Editorial

Source: EMBASE

Full Text:
Available from *EBSCOhost* in Quality in Primary Care

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