Current Awareness

Sign Up To Safety

This monthly Current Awareness Bulletin is produced by the Library, Musgrove Park Academy to provide staff with a range of resources to support Sign Up To Safety. It includes recently published guidelines and research articles, news and policy items.

This guide provides a selection of relevant resources and is not intended to be a comprehensive list. All websites have been evaluated and details are correct at the time of publications.

Details correct at time of going to print. Please note that resources are continuously updated.

For further help or guidance, please contact a member of library staff.

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Issue 5
April 2016
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Please note that abstracts are not always available for articles.

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**FALLS**

**Title:** Risk of falling for people with venous leg ulcers: a literature review

**Citation:** British Journal of Community Nursing, vol. 21, no. 3, p. S34

**Author(s):** Humphreys, Catriona, Moffatt, Christine, Hood, Victoria

**Abstract:** Introduction: Little is known about the risk of falling for people with venous leg ulcers (VLUs), and this subject has not been considered in UK populations. Many problems associated with living with VLUs are also known risk factors for sustaining a fall. This literature review considered the question: ‘Do community-dwelling older adults with VLUs have different outcomes in physical function measures used to assess the risk of falling compared with those without VLUs?’ Method: A review of quantitative literature relating to measures of physical function in people with and without VLUs was undertaken, the development of which was guided by the PRISMA guidelines. Findings: People with VLUs have poorer scores in measures of physical function than in people without. Reliability of studies included in the review was hampered by small sample sizes and threats to internal validity and generalisability. Conclusions: People with VLUs may be at a greater risk of falling owing to limitations in balance and mobility. Improving physical function may result in ulcer healing and better quality of life. Reducing falls risk may also lead to improved patient safety and enhanced care outcomes. Further research is needed to better understand the problem.

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**Title:** Evidence Levels: Applied to Select Fall and Fall Injury Prevention Practices

**Citation:** Rehabilitation Nursing, vol. 41, no. 1, p. 5-15

**Author(s):** Quigley, Patricia A.

**Abstract:** Problem: Rehabilitation nurses know the impact of injury on function, independence, and quality of life, complicated by age-related changes associated with decreased strength, endurance, reserve, frailty, and social and financial resources. Multidisciplinary teams are essential to provide expert, age specific health care delivery to this vulnerable population across settings of care. Purpose: The purpose of this article is to apply level of evidence rating scales to identify the best practice interventions to prevent falls on rehabilitation units. Key Findings and Clinical Relevance: The evidence supports the importance of determining specific risk factors and initiating multifactorial fall risk factors tailored to the individual. Yet, little evidence exists for single interventions, universal fall prevention strategies, and population-specific fall prevention strategies. A review of the literature confirms the effectiveness of many fall prevention practices and interventions remains insufficient. Of particular concern are rehabilitation units in hospitals that have higher fall rates compared to other acute units. References
Title: Falls, Balance Confidence, and Lower-Body Strength in Patients Seeking Outpatient Venous Ulcer Wound Care

Citation: Advances in Skin and Wound Care, vol. 29, no. 2, p. 85-93

Author(s): Pieper, Barbara, Templin, Thomas N

Abstract: Here, Pieper and Templin provide information about a quality improvement project examining falls in persons seeking outpatient wound care. This continuing education activity is intended for physicians and nurses with an interest in skin and wound care. Falls are a common occurrence in persons seeking outpatient wound care. Despite greater strength sufficient to perform more chair rises among those with injection-related venous ulcers (IRVUs), fall rates were comparable to those of weaker individuals with other types of VUs. With the high occurrence of falls during the project, long-term risk for fall injury would be high. Further research is needed to clarify interactions between VU risk and patient factors such as strength, age, agility, and impaired cognition.

Title: Safety Standards: Implementing Fall Prevention Interventions and Sustaining Lower Fall Rates by Promoting the Culture of Safety on an Inpatient Rehabilitation Unit

Citation: Rehabilitation Nursing, vol. 41, no. 1, p. 26-32

Author(s): Leone, Rita Marie, Adams, Rachel Joy

Abstract: Purpose: The purpose of this article is to review a quality improvement project aimed to examine how nurse leaders in an inpatient rehabilitation (IPR) unit can reduce the number of patient falls by implementing multiple fall prevention interventions and sustain their results by promoting a strong culture of safety on the unit. Design and Methods: A retrospective review of IPR fall rates was performed. Quarterly fall rates were then compared with implementation dates of fall prevention interventions (safety huddles, signage, and hourly rounding). Culture of safety scores were also examined to assess the effect of an enhanced culture of safety on the sustainability of lowered fall rates. Findings: The largest decrease in fall rate was noted after initial revitalization efforts of the IPR unit’s culture of safety concurrently with hourly rounding. Conclusions: Fall rates rise and fall despite multiple fall prevention interventions and encouraging a positive shift in the culture of safety. Clinical Relevance: Physical injuries following a fall can reduce mobility and increase morbidity. Costs associated with falls negatively impact costs and reimbursement. Employing evidence-based fall prevention strategies are then of critical importance to nurse leaders as falls remain an ongoing serious adverse event. References

Title: Cultural influences on exercise participation and fall prevention: a systematic review and narrative synthesis.

Citation: Disability & Rehabilitation, vol./is. 38/8(724-732)

Author(s): Jang, Haeyoung, Clemson, Lindy, Lovarini, Meryl, Willis, Karen, Lord, Stephen R., Sherrington, Catherine

Title: Do Falls Experienced During Inpatient Stroke Rehabilitation Affect Length of Stay, Functional Status, and Discharge Destination?

Citation: Archives of Physical Medicine & Rehabilitation. 97/4(561-566)

Author(s): Wong, Jennifer S., Brooks, Dina, Mansfield, Avril
PRESSURE ULCERS
Title: The lived experience of the wound care nurse in caring for patients with pressure ulcers.
Citation: International Wound Journal, 2016, vol./is. 13/2(243-251), 17424801
Author(s): Varga, Marlene A, Holloway, Samantha L

Title: Factors related to falls, weight-loss and pressure ulcers - more insight in risk assessment among nursing home residents.
Citation: Journal of Clinical Nursing, 2016, vol./is. 25/7/8(940-950), 09621067
Author(s): Lannering, Christina, Ernsth Bravell, Marie, Midlöv, Patrik, Östgren, Carl-Johan, Mölstad, Sigvard

Title: Knowledge and attitudes of health professionals towards pressure ulcers at a rehabilitation hospital: a cross-sectional study.
Citation: BMC Nursing, 2016, vol./is. 15/(1-6), 14726955
Author(s): Kaddourah, Bayan, Abu-Shaheen, Amani K., Al-Tannir, Mohamad
Full Text: Available from ProQuest in BMC Nursing
Available from BioMed Central in BMC Nursing
Available from National Library of Medicine in BMC Nursing

Title: USE OF A COMPREHENSIVE PROGRAM TO REDUCE THE INCIDENCE OF HOSPITAL-ACQUIRED PRESSURE ULCERS IN AN INTENSIVE CARE UNIT.
Citation: American Journal of Critical Care, 2016, vol./is. 25/2(152-155), 10623264
Author(s): Swafford, Katie
Full Text: Available from EBSCOhost in American Journal of Critical Care

Title: Pressure Ulcers: Factors Contributing to Their Development in the OR.
Citation: AORN Journal, 2016, vol./is. 103/3(271-281), 00012092
Author(s): Engels, Dawn, Austin, Melody, McNichol, Laurie, Fencil, Jennifer, Gupta, Sat, Kazi, Haseeb
Full Text: Available from ProQuest in Association of Operating Room Nurses, AORN Journal

SEPSIS
Clinical Conversations talks with Dr. Steven Simpson, author of an editorial in Chest that offers a dissent from the new definitions of sepsis. He argues that ignoring the systemic inflammatory response syndrome (commonly called SIRS) in the definition has important clinical implications.
**Title: The Utility of the Candida Score in Patients With Sepsis**

**Citation:** Dimensions of Critical Care Nursing, Mar 2016, vol. 25, no. 2, p. 92-98, 0730-4625 (Mar-Apr 2016)

**Author(s):** Umberger, Reba, Garsee, Kristen, Davidson, Brent, Carringer, Jessica Alston, Kuhl, David, Muthiah, Muthiah P.

**Abstract:** Background: Candida is a leading cause of infection in the intensive care unit. Colonization versus infection remains a challenge. A Candida Score (CS) of 3 or greater has been used to target antifungal therapy in surgical patients at risk of candidemia but has not been well evaluated in medical patients with sepsis. Objectives: The aim of this study was to assess utility of the CS in detecting candidemia early in patients with sepsis. Methods: This was a secondary analysis of patients with sepsis (n = 77) who were followed up for development of new infections. Patients with known fungal infection at admission were excluded. Candida colonization was defined as Candida cultured from any baseline culture, except blood, as a part of routine clinical care. Results: Candidemia was detected in 8 of 77 participants (10.4%; 4 [15.4%] with a CS >=3 and 4 [7.8%] with a CS <3). Demographic variables (age, race, sex) were similar among those who did and did not develop candidemia. Using the recommended CS of 3 or greater, sensitivity was (4/8) 50%, specificity was (47/69) 68.1%, positive predictive value was (4/26) 15.4%, and negative predictive value was (47/51) 92.2%. Baseline colonization was significantly higher among those who developed candidemia (50% vs 11.6%; P = .02), but no significant differences were observed among CS components or total scores. Conclusions: Despite a relatively poor sensitivity, a reasonable specificity with a strong negative predictive value makes this tool a viable option for screening medically ill patients who may require antifungal agents. The CS should be evaluated in a larger, more inclusive, medical population.

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**Title: Biomarkers in Severe Sepsis and Septic Shock: Just Listen to the Heart?**

**Citation:** Critical Care Medicine, 2016, vol./is. 44/4(849-850), 00903493

**Author(s):** Scheer, Christian, Fuchs, Christian, Rehberg, Sebastian

**Abstract:** The article discussed treatment strategies for severe sepsis and septic shock. Topics discussed includes role of myocardial dysfunction in severe sepsis and septic shock, the influence of albumin substitution on N-terminal pro-brain natriuretic peptide (NT-pro-BNP) and hs-cTnT plasma levels and the predictive value of myocardial biomarkers in patients with severe sepsis and septic shock.

**Full Text:**
Available from Ovid online collection in Critical Care Medicine
Available from Ovid fulltext collection in Critical Care Medicine

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**Title: Pregnancy-associated severe sepsis.**

**Citation:** Current opinion in obstetrics & gynecology, vol. 28, no. 2, p. 73-78

**Author(s):** Oud, Lavi

**Abstract:** This article examines the contemporary knowledge and uncertainties about the burden of pregnancy-associated severe sepsis (PASS), and its manifestations, management, and outcomes.
There are relatively sparse data on PASS, related in part to infrequent reports and varying use of terminology and case definitions. PASS remains rare, although its incidence appears to be rapidly rising in some high-resource countries, affecting especially women with limited resources, minorities, and those with chronic illness. High level of clinician vigilance and rapid initiation of appropriate antimicrobial therapy, coupled with effective systemic support for organ dysfunction and correction of occult and overt hypoperfusion are the keys to limit adverse outcomes. However, timely diagnosis and provision of effective care remain a challenge, with reported prevalent delay in recognition and delivery of time-sensitive care interventions among maternal decedents. The mortality rate of PASS has been rising and its case fatality, although relatively low, has remained unchanged, in contrast to the outcome gains in the general population. The long-term sequelae of PASS remain unknown. The relatively limited contemporary data on PASS suggest a rising public health hazard in the obstetric population in high-resource countries, with ongoing challenges in assuring consistent provision of time-sensitive care.

**Full Text:**
Available from *Ovid fulltext collection* in *Current Opinion in Obstetrics & Gynecology*  
Available from *Ovid online collection* in *Current Opinion in Obstetrics & Gynecology*

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**Title:** Defining neonatal sepsis.  
**Citation:** Current opinion in pediatrics, 28(2), p135-140  
**Author(s):** Wynn, James L  
**Abstract:** Although infection rates have modestly decreased in the neonatal intensive care unit (NICU) as a result of ongoing quality improvement measures, neonatal sepsis remains a frequent and devastating problem among hospitalized preterm neonates. Despite multiple attempts to address this unmet need, there have been minimal advances in clinical management, outcomes, and accuracy of diagnostic testing options over the last 3 decades. One strong contributor to a lack of medical progress is a variable case definition of disease. The inability to agree on a precise definition greatly reduces the likelihood of aligning findings from epidemiologists, clinicians, and researchers, which, in turn, severely hinders progress toward improving outcomes. Pediatric consensus definitions for sepsis are not accurate in term infants and are not appropriate for preterm infants. In contrast to the defined multistage criteria for other devastating diseases encountered in the NICU (e.g., bronchopulmonary dysplasia), there is significant variability in the criteria used by investigators to substantiate the diagnosis of neonatal sepsis. The lack of an accepted consensus definition for neonatal sepsis impedes our efforts toward improved diagnostic and prognostic options, and accurate outcomes information for this vulnerable population.

**Full Text:**  
Available from *Ovid online collection* in *Current Opinion in Pediatrics*  
Available from *Ovid fulltext collection* in *Current Opinion in Pediatrics*

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**Title:** Focus on infection and sepsis in intensive care patients.  
**Citation:** Intensive care medicine, vol. 42, no. 4, p. 491-493  
**Author(s):** Martin-Loeches, Ignacio, Perner, Anders

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**Title:** NHS Scotland NEWS and Sepsis Screening Tool app.  
**Citation:** Nursing standard , vol. 30, no. 30, p. 29  
**Abstract:** With NHS figures highlighting that 31,000 people die every year as a result of sepsis, this app aims to help clinicians cut the number of deaths from the condition.
DETERIORATING PATIENT

Title: Factors Influencing Registered Nurses’ Decision to Activate an Adult Rapid Response Team in a Community Hospital

Citation: Dimensions of Critical Care Nursing, vol. 25, no. 2, p. 99-107

Author(s): Jackson, Shirley, Penprase, Barbara, Grobbel, Claudia

Abstract: Background: One factor impacting patient outcomes in the acutely deteriorating patient is a delay by nursing staff to activate a rapid response team (RRT); however, a gap in knowledge exists concerning factors influencing activation of an RRT by nursing staff working in adult areas outside the medical-surgical and telemetry setting. Objectives: The purpose of this study was to examine beliefs and behaviors that influence registered nurses' decision to activate an adult rapid response team in a community hospital that includes 3 specialties: medical-surgical and telemetry, peripartum, and psychiatric areas. Methods: One hundred sixty-nine nurses were surveyed using a 17-item Likert-style instrument to assess registered nurses' beliefs and attitudes on and barriers to utilizing an RRT. Results: The survey was analyzed yielding 3 factors: RRT barriers, RRT positive/intent to activate, and patient management beliefs. Barriers cited by other research to activate RRT including criticism by the team and perception that the RRT increases workload or reduces skills were not found to be influential considerations. A significant difference was found among the 3 specialty groups related to RRT positive/intent to activate (F2,159 = 6.09, P = .003) and patient management beliefs (F2,159 = 5.87, P = .003). A strong negative correlation was found between years of experience as an RN and RRT barriers (r[ho]161 = -0.250). Discussion: Organizations should examine RRT activation delays particularly in the area of calls to covering physicians prior to RRT activations. Differences between specialty groups highlight the need for education across specialties on the recognition of the acutely deteriorating patient. The findings indicate that the inexperienced nurse requires support from experienced colleagues and temporary adjustments to workload during situations of acute deterioration of a patient. References

Title: Defining patient deterioration through acute care and intensive care nurses’ perspectives

Citation: Nursing in Critical Care, vol. 21, no. 2, p. 68-77

Author(s): Lavoie, Patrick, Pepin, Jacinthe, Alderson, Marie

Abstract: Aim: To explore the variations between acute care and intensive care nurses’ understanding of patient deterioration according to their use of this term in published literature. Background: Evidence suggests that nurses on wards do not always recognize and act upon patient deterioration appropriately. Even if resources exist to call for intensive care nurses' help, acute care nurses use them infrequently and the problem of unattended patient deterioration remains. Design: Dimensional analysis was used as a framework to analyze papers retrieved in a nursing-focused database. Method: A thematic analysis of 34 papers (2002-2012) depicting acute care and intensive care unit nurses' perspectives on patient deterioration was conducted. Findings: No explicit definition of patient deterioration was retrieved in the papers. There are variations between acute care and intensive care unit nurses' accounts of this concept, particularly regarding the validity of patient deterioration indicators. Contextual factors, processes and consequences are also explored. Conclusions: From the perspectives of acute care and intensive care nurses, patient deterioration can be defined as an evolving, predictable and symptomatic process of worsening physiology towards critical illness. Contextual factors relating to acute care units (ACU) appear as barriers to optimal care of the deteriorating patient. This work can be considered as a first effort in modelling the concept of
patient deterioration, which could be specific to ACU. Relevance to clinical practice: The findings suggest that it might be relevant to include subjective indicators of patient deterioration in track and trigger systems and educational efforts. Contextual factors impacting care for the deteriorating patient could be addressed in further attempts to deal with this issue. References

Title: Consumer participation in early detection of the deteriorating patient and call activation to rapid response systems: a literature review

Citation: Journal of Clinical Nursing, vol. 25, no. 1-2, p. 38-52

Author(s): Vorwerk, Jane, King, Lindy

Abstract: This review investigated the impact of consumer participation in recognition of patient deterioration and response through call activation in rapid response systems. Nurses and doctors have taken the main role in recognition and response to patient deterioration through hospital rapid response systems. Yet patients and visitors (consumers) have appeared well placed to notice early signs of deterioration. In response, many hospitals have sought to partner health professionals with consumers in detection and response to early deterioration. However, to date, there have been no published research-based reviews to establish the impact of introducing consumer involvement into rapid response systems. A critical research-based review was undertaken. A comprehensive search of databases from 2006-2014 identified 11 studies. Critical appraisal of these studies was undertaken and thematic analysis of the findings revealed four major themes. Following implementation of the consumer activation programmes, the number of calls made by the consumers following detection of deterioration increased. Interestingly, the number of staff calls also increased. Importantly, mortality numbers were found to decrease in one major study following the introduction of consumer call activation. Consumer and staff knowledge and satisfaction with the new programmes indicated mixed results. Initial concerns of the staff over consumer involvement overwhelming the rapid response systems did not eventuate. Evaluation of successful consumer-activated programmes indicated the importance of: effective staff education and training; ongoing consumer education by nurses and clear educational materials. Findings indicated positive patient outcomes following introduction of consumer call activation programmes within rapid response systems. Effective consumer programmes included information that was readily accessible, easy-to-understand and available in a range of multimedia materials accompanied by the explanation and support of health professionals. Introduction of consumer-activated programmes within rapid response systems appears likely to improve outcomes for patients experiencing deterioration.

Title: Vital signs monitoring and nurse-patient interaction: A qualitative observational study of hospital practice.

Citation: International journal of nursing studies, vol. 56, p. 9-16


Abstract: High profile safety failures have demonstrated that recognising early warning signs of clinical and physiological deterioration can prevent or reduce harm resulting from serious adverse events. Early warning scoring systems are now routinely used in many places to detect and escalate deteriorating patients. Timely and accurate vital signs monitoring are critical for ensuring patient safety through providing data for early warning scoring systems, but little is known about current monitoring practices. To establish a profile of nurses' vital signs monitoring practices, related dialogue, and adherence to health service protocol in New South Wales, Australia. Direct observations of nurses' working practices were conducted in two wards. The observations focused on times of the day when vital signs were generally measured. Patient interactions were recorded if occurring any time during the observation periods. Participants (n=42) included nursing staff on one chronic disease medical and one acute surgical ward in a large urban teaching hospital in New South Wales. We observed 441 patient interactions. Measurement of vital signs occurred in 52% of interactions. The minimum five vital signs measures required by New South Wales Health policy were
taken in only 6-21% of instances of vital signs monitoring. Vital signs were documented immediately on 93% of vitals-taking occasions and documented according to the policy in the patient's chart on 89% of these occasions. Nurse-patient interactions were initiated for the purpose of taking vital signs in 49% of interactions, with nurse-patient discourse observed during 88% of all interactions. Nurse-patient dialogue led to additional care being provided to patients in 12% of interactions. The selection of appropriate vital signs measured and responses to these appears to rely on nurses' clinical judgement or time availability rather than on policy-mandated frequency. The prevalence of incomplete sets of vital signs may limit identification of deteriorating patients. The findings from this study present an important baseline profile against which to evaluate the impact of introducing continuous monitoring approaches on current hospital practice. Copyright © 2015 Elsevier Ltd. All rights reserved.

Title: Improving Escalation of Care: Development and Validation of the Quality of Information Transfer Tool.

Citation: Annals of surgery, vol. 263, no. 3, p. 477-486

Author(s): Johnston, Maximilian J, Arora, Sonal, Pucher, Philip H, Reissis, Yannis, Hull, Louise, Huddy, Jeremy R, King, Dominic, Darzi, Ara

Abstract: To develop and provide validity and feasibility evidence for the QUality of Information Transfer (QUIT) tool. Prompt escalation of care in the setting of patient deterioration can prevent further harm. Escalation and information transfer skills are not currently measured in surgery. This study comprised 3 phases: the development (phase 1), validation (phase 2), and feasibility analysis (phase 3) of the QUIT tool. Phase 1 involved identification of core skills needed for successful escalation of care through literature review and 33 semi-structured interviews with stakeholders. Phase 2 involved the generation of validity evidence for the tool using a simulated setting. Thirty surgeons assessed a deteriorating postoperative patient in a simulated ward and escalated their care to a senior colleague. The face and content validity were assessed using a survey. Construct and concurrent validity of the tool were determined by comparing performance scores using the QUIT tool with those measured using the Situation-Background-Assessment-Recommendation (SBAR) tool. Phase 3 was conducted using direct observation of escalation scenarios on surgical wards in 2 hospitals. A 7-category assessment tool was developed from phase 1 consisting of 24 items. Twenty-one of 24 items had excellent content validity (content validity index >0.8). All 7 categories and 18 of 24 (P < 0.05) items demonstrated construct validity. The correlation between the QUIT and SBAR tools used was strong indicating concurrent validity (r = 0.694, P < 0.001). Real-time scoring of escalation referrals was feasible and indicated that doctors currently have better information transfer skills than nurses when faced with a deteriorating patient. A validated tool to assess information transfer for deteriorating surgical patients was developed and tested using simulation and real-time clinical scenarios. It may improve the quality and safety of patient care on the surgical ward.

Full Text: Available from Ovid online collection in Annals of Surgery
Available from Ovid fulltext collection in Annals of Surgery

PATIENT SAFETY

Title: Patient safety incident reporting: a qualitative study of thoughts and perceptions of experts 15 years after ‘To Err is Human’

Citation: BMJ Quality and Safety, vol. 25, no. 2, p. 92-99

Author(s): Mitchell, Imogen, Schuster, Anne, Smith, Katherine, Pronovost, Peter, Wu, Albert
Abstract: One of the key recommendations of the Institute of Medicine's (IOM) report, To Err is Human, 15 years ago was for greater attention to incident reporting in healthcare, analogous to the role it has played in aviation and other high-risk industries. With the passage of time and maturation of the patient safety field, we conducted semistructured interviews with 11 international patient safety experts with knowledge of the US healthcare and meeting at least one of the following criteria: (1) involved in the development of the IOM's recommendations, (2) responsible for the design and/or implementation of national or regional incident reporting systems, (3) conducted research on patient safety/incident reporting at a national level. Five key challenges emerged to explain why incident reporting has not reached its potential: poor processing of incident reports (triaging, analysis, recommendations), inadequate engagement of doctors, insufficient subsequent visible action, inadequate funding and institutional support of incident reporting systems and inadequate usage of evolving health information technology. Leading patient safety experts acknowledge the current challenges of incident reports. The future of incident reporting lies in targeted incident reporting, effective triaging and robust analysis of the incident reports and meaningful engagement of doctors. Incident reporting must be coupled with visible, sustainable action and linkage of incident reports to the electronic health record. If the healthcare industry wants to learn from its mistakes, miss or near miss events, it will need to take incident reporting as seriously as the health budget.

References

Full Text: Available from Highwire Press in BMJ Quality and Safety

Title: Patient safety is not a luxury

Citation: Lancet 387(10024), p113

HUMAN FACTORS

Title: Human factors and ergonomics for primary care.

Citation: Education for primary care: an official publication of the Association of Course Organisers, National Association of GP Tutors, World Organisation of Family Doctors, vol. 27, no. 2, p. 86-93

Author(s): Bowie, Paul, Jeffcott, Shelly

Abstract: In the second paper of this series, we provide a brief overview of the scientific discipline of human factors and ergonomics (HFE). Traditionally the HFE focus in healthcare has been in acute hospital settings which are perceived to exhibit characteristics more similar to other high-risk industries already applying related principles and methods. This paper argues that primary care is an area which could benefit extensively from an HFE approach, specifically in improving the performance and well-being of people and organisations. To this end, we define the purpose of HFE, outline its three specialist sub-domains (physical, cognitive and organisational HFE) and provide examples of guiding HFE principles and practices. Additionally, we describe HFE issues of significance to primary care education, improvement and research and outline early plans for building capacity and capability in this setting.

Title: Night shifts, human factors, and errors in the ICU: a causal pathway?

Citation: Intensive care medicine, vol. 42, no. 3, p. 456-457

Author(s): Rubulotta, F, Scales, D C, Halpern, S D

Title: Human factors and the death of a child in hospital: a case review
Learning from adverse events and errors is important if systems and processes are to be improved and to minimise the likelihood of similar events in the future. This article uses the report from a coroner’s inquest into the death of a seven-year-old child in hospital to examine errors that contributed to the child’s death. These errors are reviewed from a human factors perspective. The article provides an overview of error causation concepts and offers strategies that healthcare organisations can implement to reduce the incidence of such errors.
Organisation of health services for preventing and treating pressure ulcers
Pauline Joyce, Zena EH Moore, Janice Christie and Jo C Dumville
Online Publication Date: March 2016
New Protocol

Oral aspirin for treating venous leg ulcers
Paulo Eduardo de Oliveira Carvalho, Natiara G Magolbo, Rebeca F De Aquino and Carolina D Weller
Online Publication Date: February 2016
New review

UPTODATE

What's new from our clinical decision-making tool:

**UpToDate**

- *Falls in older persons: Risk factors and patient evaluation*
- *Falls: Prevention in nursing care facilities and the hospital setting*
- *Prevention of pressure ulcers*
- *Evaluation and management of severe sepsis and septic shock in adults*
- *Assessment and emergency management of the acutely agitated or violent adult*
- *Prevention of adverse drug events in hospitals*

Please contact library staff for details on how to access this resource; you will need an Athens password if accessing from home.

REPORTS, PUBLICATIONS AND RESOURCES

Sepsis e learning modules

A selection available here:
http://www.library.sath.nhs.uk/blog/2016/02/25/sepsis-e-learning-modules/
Free app to support Culture Change & Workforce Transformation

Do OD is the expert resource on Organisational Development for the NHS, delivered by NHS Employers in partnership with the NHS Leadership Academy.

The NHS OD community came together to create a new tool to support Culture Change in organisations.

More details here:
http://www.fabnhsstuff.net/2016/02/15/free-app-to-support-culture-change-workforce-transformation/

Learning and transparency must remain the focus in new healthcare league tables

The Department of Health has launched the ‘Learning from mistakes league’, which identifies levels of openness and transparency within NHS foundation trusts and trusts. The league table splits trusts into four divisions: those with ‘outstanding levels’ of openness and transparency; those which are ‘good’; those which have ‘significant concerns’; and those with a ‘poor reporting culture’

The UK: your partner for patient safety

This publication outlines some of the patient safety initiatives the UK is currently pursuing, and the organisations which are leading the way in standards of safety. The different sections also provide information on the partners who can best help you achieve your goal of safer, better healthcare.


An innovative way to share health promotion messages with patients on placemats at mealtimes

Read more at :
http://www.fabnhsstuff.net/2016/03/22/innovative-way-share-health-promotion-messages-patients-placemats-mealtimes/

Aintree Falls Prevention Collaborative ‘Change Package’

The problem Preventing inpatient falls has been a problem for the acute sector for many years and is associated with high risk for both the patient and the organisation. Approaches to risk reduction are
complex because of the many factors involved and the published advice is plentiful. The challenge is to
develop an approach which is both effective and sustainable.

Read more at:

Freda’s Fall – an innovative e-learning film on falls management

Freda’s Fall is an interactive e-learning film focused on the prevention and management of falls
– Aimed at all healthcare professionals and associated staff and service users with a particular interest in
  falls and frailty
– Designed to enhance the knowledge and understanding of falls management through a mix of video,
  informational and instructional text.

Read more at:

Recognize and Rescue

This Future Hospital Programme case study comes from Dr Mark Simmonds at Nottingham University Hospitals (NUH) NHS Trust. He describes how the ‘Recognise and Rescue’ programme is improving the care of the deteriorating patient.

Read more at:
http://www.fabnhsstuff.net/2016/03/14/recognize-and-rescue/
Looking for the latest evidence-based research but haven’t got time to trawl the databases?

Do you need a literature search carried out?

Do you need to find evidence to support an improvement?

Do you want to know how something has been done elsewhere and whether it worked?

Library staff provide a literature search service for busy clinicians who are pressed for time.

To request a search please complete and return the attached form, providing as much information as possible. Alternatively if you would like an assisted search training session, where we will sit down with you and go through the steps of a literature search, then please contact the library.

Most electronic resources are available via an Athens password. You can register for this via the Library intranet page, or from home at www.swice.nhs.uk and following the link for Athens self-registration.

Please note that registering from home will take longer as it will need to be verified that you are NHS staff/student on placement.

The library offers training on how to access and use Athens resources, as well as an introductory course on critical appraisal. You can book a course through the Learning and Development intranet page, or by contacting the library directly.