Current Awareness

Sign Up To Safety

This monthly Current Awareness Bulletin is produced by the Library Team, 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.

This guide has been compiled by:

Carol-Ann Regan
Musgrove Park Hospital Library Service

Carol-ann.regan@tst.nhs.uk

@musgrovesompar
http://librarymph.wordpress.com/

Issue 10
September 2016
## Contents

Click on a section title to navigate contents

<table>
<thead>
<tr>
<th>Section</th>
<th>Page</th>
</tr>
</thead>
<tbody>
<tr>
<td>Recent journal articles</td>
<td>3</td>
</tr>
<tr>
<td>Books</td>
<td>26</td>
</tr>
<tr>
<td>UpToDate and Dynamed Plus</td>
<td>27</td>
</tr>
<tr>
<td>Reports, publications and resources</td>
<td>28</td>
</tr>
<tr>
<td>Literature search service</td>
<td>31</td>
</tr>
<tr>
<td>Training and Athens</td>
<td>31</td>
</tr>
</tbody>
</table>

---

### Library contact details:

Library  
Musgrove Park Academy  
Musgrove Park Hospital  
Taunton  
Somerset  
TA1 5DA  

Tel: 01823 34 (2433)  
Fax: 01823 34 (2434)  

Email: library@tst.nhs.uk  
Blog: [http://librarymph.wordpress.com](http://librarymph.wordpress.com)  
@musgrovesompar
Some articles are available in the library or on-line via an OpenAthens password by following the full-text link. If you would like an article which is not available as full-text then please contact library staff.

Please note that abstracts are not always available for articles.

FALLS

Title: Multidisciplinary Testing of Floor Pads on Stability, Energy Absorption, and Ease of Hospital Use for Enhanced Patient Safety.

Citation: Journal of patient safety, Sep 2016, vol. 12, no. 3, p. 132-139

Author(s): Crane, Barbara, Goodworth, Adam D, Liquori, Melissa, Ghosh, Suhash, Certo, Catherine, McCafferty, Lorraine

Abstract: A major improvement in hospital safety could be realized if serious injury did not accompany falls. We studied several commercially available floor pads made of different materials to determine which (if any) would be practical in a hospital room and reduce injury without posing a threat to the balance of patients. A multidisciplinary approach was undertaken to (1) measure upper and lower body motion in 17 young (<50 years) and 17 older (>55 years) adults during an instrumented sit to stand test from a hospital bed onto the different floor pads, (2) predict the energy dissipation available in floor pads by quantifying the relative mechanical properties, and (3) obtain professional feedback from hospital nurses via a questionnaire (8 questions) following a period of working on the different floor pads. Five floor pads, composed of foam, gel, and/or rubber were tested. All pads were compared with a typical hospital floor (concrete covered with linoleum tiles, considered the control). All of the pads subject to mechanical testing showed at least 3 times more energy absorption compared with the control. Balance testing showed that three of the pads resulted in minimal or no significant increases in body motion during sit-to-stand. Nursing feedback revealed that only 2 of these 3 pads may be feasible for hospital room use: one made primarily of firm rubber and one made of foam. Floor pads do exist that show promise for hospital use that absorbing energy without major impacts on balance during sit-to-stand. Although only commercially available pads were investigated, results may inform the design and multidisciplinary testing of other floor surfaces.

Source: Medline

Title: Effectiveness of a fall-risk reduction programme for inpatient rehabilitation after stroke.

Citation: Disability and rehabilitation, Sep 2016, vol. 38, no. 18, p. 1811-1819
**Author(s):** Goljar, Nika, Globokar, Daniel, Puzić, Nataša, Kopitar, Natalija, Vrabič, Maja, Ivanovski, Matic, Vidmar, Gaj

**Abstract:** To evaluate effectiveness of fall-risk-assessment-based fall prevention for stroke rehabilitation inpatients. A consecutive series of 232 patients admitted for the first time to a subacute stroke-rehabilitation ward during 2010-2011 was studied in detail. The Assessment Sheet for Fall Prediction in Stroke Inpatients (ASFPSI by Nakagawa et al.) was used to assess fall-risk upon admission. Association of ASFPSI score and patient characteristics with actual falls was statistically tested. Yearly incidence of falls per 1000 hospital days (HD) was retrospectively audited for the 2006-2014 period to evaluate effectiveness of fall-risk reduction measures. The observed incidence of falls over the detailed-study-period was 3.0/1000 HD; 39% of the fallers fell during the first week after admission. ASFPSI score was not significantly associated with falls. Longer hospital stay, left body-side affected and non-extreme FIM score (55-101) were associated with higher odds of fall. Introduction of fall-risk reduction measures followed by compulsory fall-risk assessment lead to incidence of falls dropping from 7.1/1000 HD in 2006 to 2.8/1000 HD in 2011 and remaining at that level until 2014. The fall-risk-assessment-based measures appear to have led to decreasing falls risk among post-stroke rehabilitation inpatients classified as being at high risk of falls. The fall prevention programme as a whole was successful. Patients with non-extreme level of functional independence should receive enhanced fall prevention. Implications for Rehabilitation Recognising the fall risk upon the patient's admission is essential for preventing falls in rehabilitation wards. Assessing the fall risk is a team tasks and combines information from various sources. Assessing fall risk in stroke patients using the assessment sheet by Nakagawa et al. immediately upon admission systematically draws attention to the risk of falls in each individual patient.

**Source:** Medline

---

**Title:** Iterative user centered design for development of a patient-centered fall prevention toolkit.

**Citation:** Applied ergonomics, Sep 2016, vol. 56, p. 117-126

**Author(s):** Katsulis, Zachary, Ergai, Awatef, Leung, Wai Yin, Schenkel, Laura, Rai, Amisha, Adelman, Jason, Benneyan, James, Bates, David W, Dykes, Patricia C

**Abstract:** Due to the large number of falls that occur in hospital settings, inpatient fall prevention is a topic of great interest to patients and health care providers. The use of electronic decision support that tailors fall prevention strategy to patient-specific risk factors, known as Fall T.I.P.S (Tailoring Interventions for Patient Safety), has proven to be an effective approach for decreasing hospital falls. A paper version of the Fall T.I.P.S toolkit was developed primarily for hospitals that do not have the resources to implement the electronic solution; however, more work is needed to optimize the effectiveness of the paper version of this tool. We examined the use of human factors techniques in the redesign of the existing paper fall prevention tool with the goal of increasing ease of use and decreasing inpatient falls. The inclusion of patients and clinical staff in the redesign of the existing tool was done to increase adoption of the tool and fall prevention best practices. The redesigned
paper Fall T.I.P.S toolkit showcased a built in clinical decision support system and increased ease of use over the existing version. Copyright © 2016 Elsevier Ltd. All rights reserved.

Source: Medline

Title: An Interprofessional Approach to Reducing the Risk of Falls Through Enhanced Collaborative Practice.

Citation: Journal of the American Geriatrics Society, Aug 2016, vol. 64, no. 8, p. 1701-1707

Author(s): Eckstrom, Elizabeth, Neal, Margaret B, Cotrell, Vicki, Casey, Colleen M, McKenzie, Glenise, Morgove, Megan W, DeLander, Gary E, Simonson, William, Lasater, Kathie

Abstract: Falls are the leading cause of accidental deaths in older adults and are a growing public health concern. The American Geriatrics Society (AGS) and British Geriatrics Society (BGS) published guidelines for falls screening and risk reduction, yet few primary care providers report following any guidelines for falls prevention. This article describes a project that engaged an interprofessional teaching team to support interprofessional clinical teams to reduce fall risk in older adults by implementing the AGS/BGS guidelines. Twenty-five interprofessional clinical teams with representatives from medicine, nursing, pharmacy, and social work were recruited from ambulatory, long-term care, hospital, and home health settings for a structured intervention: a 4-hour training workshop plus coaching for implementation for 1 year. The workshop focused on evidence-based strategies to decrease the risk of falls, including screening for falls; assessing gait, balance, orthostatic blood pressure, and other medical conditions; exercise including tai chi; vitamin D supplementation; medication review and reduction; and environmental assessment. Quantitative and qualitative data were collected using chart reviews, coaching plans and field notes, and postintervention structured interviews of participants. Site visits and coaching field notes confirmed uptake of the strategies. Chart reviews showed significant improvement in adoption of all falls prevention strategies except vitamin D supplementation. Long-term care facilities were more likely to address environmental concerns and add tai chi classes, and ambulatory settings were more likely to initiate falls screening. The intervention demonstrated that interprofessional practice change to target falls prevention can be incorporated into primary care and long-term care settings. © 2016, Copyright the Authors Journal compilation © 2016, The American Geriatrics Society.

Source: Medline

Title: Etiology of Syncope and Unexplained Falls in Elderly Adults with Dementia: Syncope and Dementia (SYD) Study.

Citation: Journal of the American Geriatrics Society, Aug 2016, vol. 64, no. 8, p. 1567-1573

Author(s): Ungar, Andrea, Mussi, Chiara, Ceccefiglio, Alice, Bellelli, Giuseppe, Nicosia, Franco, Bo, Mario, Riccio, Daniela, Martone, Anna Maria, Guadagno, Livia, Noro, Gabriele, Ghidoni, Giulia, Rafanelli, Martina, Marchionni, Niccolò, Abete, Pasquale
Abstract: To investigate the etiology of transient loss of consciousness (T-LOC) suspected to be syncope and unexplained falls in elderly adults with dementia. Prospective, observational, multicenter study. Acute care wards, syncope units or centers for the diagnosis of dementia. Individuals aged 65 and older with a diagnosis of dementia and one or more episodes of T-LOC of a suspected syncopal nature or unexplained falls during the previous 3 months were enrolled. The causes of T-LOC suspected to be syncope and unexplained falls were evaluated using a simplified protocol based on European Society of Cardiology guidelines. Of 357 individuals enrolled, 181 (50.7%) had been referred for T-LOC suspected to be syncope, 166 (46.5%) for unexplained falls, and 10 (2.8%) for both. An initially suspected diagnosis of syncope was confirmed in 158 (87.3%), and syncope was identified as the cause of the event in 75 (45.2%) of those referred for unexplained falls. Orthostatic hypotension was the cause of the event in 117 of 242 (48.3%) participants with a final diagnosis of syncope. The simplified syncope diagnostic protocol can be used in elderly people with dementia referred for suspected syncope or unexplained falls. Unexplained falls may mask a diagnosis of syncope or pseudosyncope in almost 50% of cases. Given the high prevalence of orthostatic syncope in participants (~50%), a systematic reappraisal of drugs potentially responsible for orthostatic hypotension is warranted. © 2016, Copyright the Authors Journal compilation © 2016, The American Geriatrics Society.

Source: Medline

Title: Assessment for benign paroxysmal positional vertigo in medical patients admitted with falls in a district general hospital.

Citation: Clinical medicine (London, England), Aug 2016, vol. 16, no. 4, p. 335-338

Author(s): Abbott, Joel, Tomassen, Sylvia, Lane, Laura, Bishop, Katie, Thomas, Nibu

Abstract: Having benign paroxysmal positional vertigo (BPPV) puts patients at a significantly higher risk of falling. It is poorly recognised and diagnosis is frequently delayed. BPPV has been studied in outpatient settings, but there have been no studies looking at the prevalence in patients admitted with falls. This study aims to establish how common BPPV is in these patients. For a 4-month period, patients admitted on an unselected medical take were screened for an admission precipitated by a fall. Patients who consented were assessed for BPPV using the Dix-Hallpike manoeuvre. Patients who tested positive were treated using the Epley manoeuvre. The assessments were carried out by specialist physiotherapists who were experienced at assessing and diagnosing patients with peripheral vestibular disorders. Out of the 111 patients initially identified, 37 (33%) were considered to be appropriate and consented to be part of the study. Of these, 20 patients (54%) had a positive Dix-Hallpike manoeuvre. Of the patients included in the study, over half tested positive for BPPV. This merits further study. Potentially, there is a proportion of patients admitted with falls who have an easily treatable contributing factor that is not being identified with standard practice. © 2016 Royal College of Physicians.

Source: Medline

Full Text:
Title: Problematising the problem: a critical interpretive review of the literature pertaining to older people with cognitive impairment who fall while hospitalised

Citation: Nursing Inquiry, Jun 2016, vol. 23, no. 2, p. 148-157

Author(s): Rushton, Carole

Abstract: This article presents a reflexive account by way of a critical interpretive review of the literature pertaining to falls of older people with cognitive impairment who have been hospitalised in an acute care setting. A key aim of this review was to use thematic analysis and problematisation to challenge assumptions underpinning the current falls literature and to bring into consideration alternate foci of research and new approaches to falls research. An innovative approach is used to generate descriptive and interpretive summaries of the literature which are presented graphically to reveal the prevailing themes and assumptions within. It is argued that currently, falls research in the context of cognitive impairment is constrained by scientism. Meta-paradigmatic approaches, which have the potential to provide a better understanding of why falls may or may not occur among this particular subgroup of older people, are proposed as an alternative. [PUBLICATION] References

Source: BNI

Title: Agreement between the frailty index and phenotype and their associations with falls and overnight hospitalizations.

Citation: Archives of Gerontology & Geriatrics, 2016, vol./is. 66/(161-165)

Author(s): Zhu, Yinsheng, Liu, Zuyun, Wang, Yong, Wang, Zhengdong, Shi, Jianming, Xie, Xuejuan, Jin, Li, Chu, Xuefeng, Wang, Xiaofeng

Source: CINAHL

Title: Patient perceptions and experiences with falls during hospitalization and after discharge.

Citation: Applied Nursing Research, 2016, vol./is. 31/(79-85)

Author(s): Shuman, Clayton, Jia Liu, Montie, Mary, Galinato, Jose Gabriel, Todd, Molly A., Hegstad, Marcia, Titler, Marita

Source: CINAHL

Title: Falls risk assessment in older patients in hospital.

Citation: Nursing Standard, 2016, vol./is. 30/48(53-61)
Author(s): Matarese, Maria, Ivziku, Dhurata

Source: CINAHL

Full Text: Available from NURSING STANDARD in Library MPH

PRESSURE ULCERS

Title: Benefits of Early Active Mobility in the Medical Intensive Care Unit: A Pilot Study.

Citation: The American journal of medicine, Aug 2016, vol. 129, no. 8, p. 866

Author(s): Azuh, Ogochukwu, Gammon, Harriet, Burmeister, Charlotte, Frega, Donald, Nerenz, David, DiGiovine, Bruno, Siddiqui, Aamir

Abstract: Pressure ulcer formation continues to be problematic in acute care settings, especially intensive care units (ICUs). Our institution developed a program for early mobility in the ICU using specially trained nursing aides. The goal was to impact hospital-acquired pressure ulcers incidence as well as factors associated with ICU deconditioning by using specially trained personnel to perform the acute early mobility interventions. A 5-point mobility scale was developed and used to establish a patient's highest level of activity achievable during evaluation. A mobility team was created consisting of skin-care prevention/mobility nurses and a new category of worker called a patient mobility assistant. Each level has a corresponding plan of care (intervention) that was followed and adjusted according to the patient's progress and nursing evaluation. Data collection included the type of interventions at each encounter, mobility and skin assessments, new hospital-acquired pressure ulcer, the current mobility level, Braden score, rate of ventilator-associated pneumonia, ICU length of stay, and hospital readmission. Staff was also surveyed about their attitudes toward mobilization and perception of mobility barriers; a pre-pilot and a post-pilot survey were planned. During the 1-year study interval, 3233 patients were enrolled from the medical intensive care unit (MICU). The 2011 pre-implementation MICU hospital-acquired pressure ulcer rate was 9.2%. After 1 year of employing the mobility team, there was a statistically significant decrease in the MICU hospital-acquired pressure ulcer rate to 6.1% (P = .0405). Hospital readmission of MICU patients also significantly decreased from 17.1% to 11.5% (P = .0010). The mean MICU length of stay decreased by 1 day. There were no safety issues directly or indirectly associated with these interventions. Use of this mobility program resulted in a 3% decrease in the most recalcitrant patients in the MICU. This corresponds to a decrease of 1.2 per 1000 patient days. It is definitely both statistically and clinically significant. We believe this lays the groundwork for further work in this area. We have shown that properly trained nonlicensed professionals can safely and effectively mobilize patients in the ICU setting. This can represent a cost-effective way to introduce early mobility in the ICU setting. Copyright © 2016 Elsevier Inc. All rights reserved.

Source: Medline
Title: Automatic limb identification and sleeping parameters assessment for pressure ulcer prevention.

Citation: Computers in biology and medicine, Aug 2016, vol. 75, p. 98-108

Author(s): Baran Pouyan, Maziyar, Birjandtalab, Javad, Nourani, Mehrdad, Matthew Pompeo, M D

Abstract: Pressure ulcers (PUs) are common among vulnerable patients such as elderly, bedridden and diabetic. PUs are very painful for patients and costly for hospitals and nursing homes. Assessment of sleeping parameters on at-risk limbs is critical for ulcer prevention. An effective assessment depends on automatic identification and tracking of at-risk limbs. An accurate limb identification can be used to analyze the pressure distribution and assess risk for each limb. In this paper, we propose a graph-based clustering approach to extract the body limbs from the pressure data collected by a commercial pressure map system. A robust signature-based technique is employed to automatically label each limb. Finally, an assessment technique is applied to evaluate the experienced stress by each limb over time. The experimental results indicate high performance and more than 94% average accuracy of the proposed approach. Copyright © 2016 Elsevier Ltd. All rights reserved.

Source: Medline

---

Title: Factors Associated With Treatment Failure of Infected Pressure Sores.

Citation: Annals of surgery, Aug 2016, vol. 264, no. 2, p. 399-403

Author(s): Jugun, Kheeldass, Richard, Jean-Christophe, Lipsky, Benjamin A, Kressmann, Benjamin, Pittet-Cuenod, Brigitte, Suvà, Domizio, Modarressi, Ali, Uçkay, Ilker

Abstract: In this study, we assess interdisciplinary surgical and medical parameters associated to recurrences of infected pressure ulcers. There is a little in the published literature regarding factors associated with the outcome of treatment of infected pressure ulcers. We undertook a single-center review of spinal injured adults hospitalized for an infected pressure ulcer or implant-free osteomyelitis and reviewed the literature on this topic from 1990-2015. We found 70 lesions in 31 patients (52 with osteomyelitis) who had a median follow-up of 2.7 years (range, 4 months to 19 years). The median duration of antibiotic therapy was 6 weeks, of which 1 week was parenteral. Clinical recurrence after treatment was noted in 44 infected ulcers (63%), after a median interval of 1 year. In 86% of these recurrences, cultures yielded a different organism than the preceding episode. By multivariate analyses, the following factors were not significantly related to recurrence: number of surgical interventions (hazard ratio 0.9, 95% confidence interval 0.5-1.5); osteomyelitis (hazard ratio 1.5; 0.7-3.1); immune suppression; prior sacral infections, and duration of total (or just parenteral) antibiotic sue. Patients with antibiotic treatment for <6 weeks had the same failure rate as those with as >12 weeks (χ test; P=0.90). In patients with infected pressure ulcers, clinical recurrence occurs in almost two-thirds of lesions, but in only 14% with the same pathogen(s). The number of surgical debridements, flap use, or duration
of antibiotic therapy was not associated with recurrence, suggesting recurrences are caused by reinfections caused by other extrahospital factors.

**Source:** Medline

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

---

**Title:** Pressure ulcer healing with an intensive nutrition intervention in an acute setting: a pilot randomised controlled trial.

**Citation:** Journal of wound care, Jul 2016, vol. 25, no. 7, p. 384-392

**Author(s):** Banks, M D, Ross, L J, Webster, J, Mudge, A, Stankiewicz, M, Dwyer, K, Coleman, K, Campbell, J

**Abstract:** To investigate the feasibility of recruitment, retention, intervention delivery and outcome measurement in a nutritional intervention to promote pressure ulcer healing in an acute setting. Some 50 tertiary hospital patients with stage II or greater pressure ulcer were randomised to receive either individualised nutritional care by a dietitian, including prescription of wound healing supplements; or standard nutritional care. Relevant nutritional and pressure ulcer (PU) parameters were collected at day 5, 10, 15, 22 and then weekly or until discharge. The median length of hospital stay was 14 days (1-70) with 29 patients discharged by day 15. There were 24 patients discharged before their PU fully healed. Percent change in valid PU area and score measures from baseline to day 15 were chosen for outcome data analysis to account for varying initial size and severity of the wound and length of stay. There was a larger percentage reduction in PU measures in the intervention group, but this was not statistically significant. Little difference was found in nutritional intake between the control and intervention groups indicating a requirement to focus on effective delivery of the intervention in future studies. Future studies in the acute setting need to account for length of stay and ideally follow patients until full healing. Results indicate a positive association with nutrition intervention and PU healing and that a rigorously designed and adequately powered study is feasible. This research was supported by a grant from the Queensland Health, Health Practitioner Research Scheme. The authors have no conflicts of interest to declare.

**Source:** Medline

**Full Text:**
Available from *Mark Allen Group* in *Journal of Wound Care*

---

**Title:** Characteristics of patients who are admitted with or acquire Pressure Ulcers in a District General Hospital; a 3 year retrospective analysis

**Citation:** Nursing Open, Jul 2016, vol. 3, no. 3, p. 152-158

**Author(s):** Worsley, Peter R., Smith, Glenn, Schoonhoven, Lisette, Bader, Dan L.
Abstract: Aim: The study aimed to characterize demographic and clinical practice factors associated with community (CAPU) and hospital acquired pressure ulcers (HAPU). Design: A comparative retrospective evaluation of pressure ulcer data, collected from a district general hospital. Methods: Demographic and pressure ulcer related data were collected from patients at risk of developing a pressure ulcer, collated by a single observer using a standardized tool. Comparisons were made within and between patient groups (no PU, CAPU and HAPU). Results: CAPU and HAPU patient groups were significantly (P < 0.001) older, had extended lengths of hospital stay and were less likely to be provided quickly with a pressure relieving support surface than those with no PU. HAPU patients had a longer length of stay and a higher proportion of heel PUs compared to CAPU. References

Source: BNI

Title: The relationship among pressure ulcer risk factors, incidence and nursing documentation in hospital-acquired pressure ulcer patients in intensive care units.

Citation: Journal of Clinical Nursing, 2016, vol./is. 25/15/16(2336-2347)

Author(s): Li, Dan

Source: CINAHL

Title: Reliability of Pressure Ulcer Rates: How Precisely Can We Differentiate Among Hospital Units, and Does the Standard Signal-Noise Reliability Measure Reflect This Precision?

Citation: Research in Nursing & Health, 2016, vol./is. 39/4(298-305)

Author(s): Staggs, Vincent S., Cramer, Emily

Source: CINAHL

Title: Improving Hospital-Acquired Pressure Ulcer Prevention on an Orthopedic Unit.

Citation: MEDSURG Nursing, 2016, vol./is. 1/(4-7)

Author(s): Tashman, Naomi

Source: CINAHL

Full Text: Available from ProQuest in Medsurg Nursing
Available from EBSCOhost in MEDSURG Nursing
SEPSIS

Title: Effect of Early Vasopressin vs Norepinephrine on Kidney Failure in Patients With Septic Shock. The VANISH Randomized Clinical Trial.

Authors: Gordon et al

Citation: JAMA 2016;316(5):509-518

Abstract


Title: Predictors of early progression to severe sepsis or shock among emergency department patients with nonsevere sepsis.

Citation: International journal of emergency medicine, Dec 2016, vol. 9, no. 1, p. 10

Author(s): Holder, Andre L, Gupta, Namita, Lulaj, Elizabeth, Furgiuele, Miriam, Hidalgo, Idaly, Jones, Michael P, Jolly, Tiphany, Gennis, Paul, Birnbaum, Adrienne

Abstract: Progression from nonsevere sepsis-i.e., sepsis without organ failure or shock-to severe sepsis or shock among emergency department (ED) patients has been associated with significant mortality. Early recognition in the ED of those who progress to severe sepsis or shock during their hospital course may improve patient outcomes. We sought to identify clinical, demographic, and laboratory parameters that predict progression to severe sepsis, septic shock, or death within 96 h of ED triage among patients with initial presentation of nonsevere sepsis. This is a retrospective cohort of patients presenting to a single urban academic ED from November 2008 to October 2010. Patients aged 18 years or older who met criteria for sepsis and had a lactate level measured in the ED were included. Patients were excluded if they had any combination of the following: a systolic blood pressure <90 mmHg upon triage, an initial whole blood lactate level ≥4 mmol/L, or one or more of a set of predefined signs of organ dysfunction upon initial assessment. Disease progression was defined as the development of any combination of the aforementioned conditions, initiation of vasopressors, or death within 96 h of ED presentation. Data on predefined potential predictors of disease progression and outcome measures of disease progression were collected by a query of the electronic medical record and via chart review. Logistic regression was used to assess associations of potential predictor variables with a composite outcome measure of sepsis progression to organ failure, hypotension, or death. In this cohort of 582 ED patients with nonsevere sepsis, 108 (18.6 %) experienced disease progression. Initial serum albumin <3.5 mg/dL (OR 4.82; 95 % CI 2.40-9.69; p < 0.01) and a diastolic blood pressure <52 mmHg at ED triage (OR 4.59; 95 % CI 1.57-13.39; p < 0.01) were independently associated with disease progression to severe sepsis or shock within 96 h of ED presentation. There were no deaths within 96 h of ED presentation. In our patient cohort, serum albumin <3.5 g/dL and an ED triage diastolic blood pressure <52 mmHg independently predict early progression to severe sepsis or shock among ED patients with presumed sepsis.
Title: Accurate coding in sepsis: clinical significance and financial implications.

Citation: The Journal of hospital infection, Sep 2016, vol. 94, no. 1, p. 99-102

Author(s): Chin, Y T, Scattergood, N, Thornber, M, Thomas, S

Abstract: Sepsis is a major healthcare problem and leading cause of death worldwide. UK hospital mortality statistics and payments for patient episodes of care are calculated on clinical coding data. The accuracy of these data depends on the quality of coding. This study aimed to investigate whether patients with significant bacteraemia are coded for sepsis and to estimate the financial costs of miscoding. Of 54 patients over a one-month period with a significant bacteraemia, only 19% had been coded for sepsis. This is likely to lead to falsely high calculated hospital mortality. Furthermore, this resulted in an underpayment of £21,000 for one month alone. Copyright © 2016 The Healthcare Infection Society. All rights reserved.

Source: Medline

Title: Sepsis Early Alert Tool: Early recognition and timely management in the emergency department.

Citation: Emergency medicine Australasia : EMA, Aug 2016, vol. 28, no. 4, p. 399-403

Author(s): Idrees, Marwan, Macdonald, Stephen Pj, Kodali, Kiren

Abstract: The Surviving Sepsis Campaign guidelines recommend administration of appropriate antibiotics within 1 h in patients with severe sepsis, with two sets of blood cultures taken prior to administration. We evaluated the effect of introducing a Sepsis Early Alert Tool (SEAT) in the ED. Outcomes were antibiotic timing, antibiotic choice and obtaining adequate blood cultures. A retrospective chart review compared consecutive severe sepsis presentations admitted to ICU via the ED during two equivalent 6 month periods before and after SEAT introduction. The analyses included 55 patients before and 45 following SEAT introduction. The groups were similar in age, sex, triage category, sepsis source, Acute Physiology and Chronic Health Evaluation III scores and hospital mortality. The percentage receiving antibiotics within 60 min of triage increased from 24% (95% CI 13-37%) to 44% (95% CI 30-60%), P = 0.03. Median time from triage to first antibiotic was 105 (IQR 65-170) min and 85 (IQR 50-140) min before and after SEAT introduction, respectively, P = 0.15. Percentages receiving antibiotics within 60 min of first recognition of
Severe sepsis were 67% (95% CI 53-79%) and 71% (95% CI 56-84%) before and after SEAT introduction, P = 0.83. The percentage having two sets of blood cultures drawn prior to antibiotic administration increased from 18% (95% CI 9-34%) to 44% (95% CI 27-60%), P = 0.008. Appropriateness of antibiotics was 58% (95% CI 44-71%) and 75% (95% CI 60-87%) before and after SEAT implementation, P = 0.09. The introduction of a SEAT in the ED is associated with earlier recognition of severe sepsis and improvements in quality of care. © 2016 Australasian College for Emergency Medicine and Australasian Society for Emergency Medicine.

Source: Medline

Title: Impact of Prehospital Care on Outcomes in Sepsis: A Systematic Review.

Citation: The western journal of emergency medicine, Jul 2016, vol. 17, no. 4, p. 427-437

Author(s): Smyth, Michael A, Brace-McDonnell, Samantha J, Perkins, Gavin D

Abstract: Sepsis is a common and potentially life-threatening response to an infection. International treatment guidelines for sepsis advocate that treatment be initiated at the earliest possible opportunity. It is not yet clear if very early intervention by ambulance clinicians prior to arrival at hospital leads to improved clinical outcomes among sepsis patients. We systematically searched the electronic databases MEDLINE, EMBASE, CINAHL, the Cochrane Library and PubMed up to June 2015. In addition, subject experts were contacted. We adopted the GRADE (grading recommendations assessment, development and evaluation) methodology to conduct the review and follow PRISMA (Preferred Reporting Items for Systematic Reviews and Meta-Analyses) recommendations to report findings. Nine studies met the eligibility criteria - one study was a randomized controlled trial while the remaining studies were observational in nature. There was considerable variation in the methodological approaches adopted and outcome measures reported across the studies. Because of these differences, the studies did not answer a unique research question and meta-analysis was not appropriate. A narrative approach to data synthesis was adopted. There is little robust evidence addressing the impact of prehospital interventions on outcomes in sepsis. That which is available is of low quality and indicates that prehospital interventions have limited impact on outcomes in sepsis beyond improving process outcomes and expediting the patient's passage through the emergency care pathway. Evidence indicating that prehospital antibiotic therapy and fluid resuscitation improve patient outcomes is currently lacking.

Source: Medline

Full Text: Available from National Library of Medicine in Western Journal of Emergency Medicine

Title: The Third International Consensus Definitions for Sepsis and Septic Shock (Sepsis-3).
Citation: JAMA: Journal of the American Medical Association, 2016, vol./is. 315/8(801-810)


Abstract: Importance: Definitions of sepsis and septic shock were last revised in 2001. Considerable advances have since been made into the pathobiology (changes in organ function, morphology, cell biology, biochemistry, immunology, and circulation), management, and epidemiology of sepsis, suggesting the need for reexamination. Objective: To evaluate and, as needed, update definitions for sepsis and septic shock. Process: A task force (n = 19) with expertise in sepsis pathobiology, clinical trials, and epidemiology was convened by the Society of Critical Care Medicine and the European Society of Intensive Care Medicine. Definitions and clinical criteria were generated through meetings, Delphi processes, analysis of electronic health record databases, and voting, followed by circulation to international professional societies, requesting peer review and endorsement (by 31 societies listed in the Acknowledgment). Key Findings from Evidence Synthesis: Limitations of previous definitions included an excessive focus on inflammation, the misleading model that sepsis follows a continuum through severe sepsis to shock, and inadequate specificity and sensitivity of the systemic inflammatory response syndrome (SIRS) criteria. Multiple definitions and terminologies are currently in use for sepsis, septic shock, and organ dysfunction, leading to discrepancies in reported incidence and observed mortality. The task force concluded the term severe sepsis was redundant. Recommendations: Sepsis should be defined as life-threatening organ dysfunction caused by a dysregulated host response to infection. For clinical operationalization, organ dysfunction can be represented by an increase in the Sequential [Sepsis-related] Organ Failure Assessment (SOFA) score of 2 points or more, which is associated with an in-hospital mortality greater than 10%. Septic shock should be defined as a subset of sepsis in which particularly profound circulatory, cellular, and metabolic abnormalities are associated with a greater risk of mortality than with sepsis alone. Patients with septic shock can be clinically identified by a vasopressor requirement to maintain a mean arterial pressure of 65 mm Hg or greater and serum lactate level greater than 2 mmol/L (>18 mg/dL) in the absence of hypovolemia. This combination is associated with hospital mortality rates greater than 40%. In out-of-hospital, emergency department, or general hospital ward settings, adult patients with suspected infection can be rapidly identified as being more likely to have poor outcomes typical of sepsis if they have at least 2 of the following clinical criteria that together constitute a new bedside clinical score termed quickSOFA (qSOFA): respiratory rate of 22/min or greater, altered mentation, or systolic blood pressure of 100 mm Hg or less. Conclusions and Relevance: These updated definitions and clinical criteria should replace previous definitions, offer greater consistency for epidemiologic studies and clinical trials, and facilitate earlier recognition and more timely management of patients with sepsis or at risk of developing sepsis.

Source: CINAHL
DETERIORATING PATIENT

Title: The Impact of Implementation of Family-Initiated Escalation of Care for the Deteriorating Patient in Hospital: A Systematic Review.

Citation: Worldviews on Evidence-Based Nursing, 2016, vol./is. 13/4(303-313)

Author(s): Gill, Fenella J., Leslie, Gavin D., Marshall, Andrea P.

Source: CINAHL

Title: Strengthening the afferent limb of rapid response systems: an educational intervention using web-based learning for early recognition and responding to deteriorating patients.

Citation: BMJ Quality & Safety, 2016, vol./is. 25/6(448-456)

Author(s): Sok Ying Liaw, Lai Fun Wong, Bee Leng Ang, Sophia, Tze Yin Ho, Jasmine, Chiang Siau, Neo Kim Ang, Emily

Source: CINAHL

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

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, 2016, vol./is. 25/1/2(38-52)

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

Source: CINAHL

Title: A mixed-methods investigation of health professionals' perceptions of a physiological track and trigger system.

Citation: BMJ quality & safety, Sep 2016, vol. 25, no. 9, p. 688-695

Author(s): Lydon, Sinéad, Byrne, Dara, Offiah, Gozie, Gleeson, Louise, O'Connor, Paul

Abstract: Physiological track and trigger systems (PTTSs) regulate the monitoring of patients' vital signs and facilitate the detection and treatment of deteriorating patients. These systems are widely used, although compliance with protocol is often poor. This study aimed to examine the perceptions of a national PTTS among nurses and doctors and to identify the variables that impact on intention to comply with protocol. A mixed-methods research design was employed. During the initial qualitative phase, 30 hospital-based nurses and doctors...
participated in a series of semistructured interviews. During the subsequent quantitative phase, 215 nurses and doctors (24.1% response rate) responded to a questionnaire designed to assess attitudes towards the PTTS and factors that influence adherence to protocol. Interview data revealed largely positive attitudes towards the PTTS but highlighted a number of barriers to its implementation and indicated that it is sometimes a source of tension between doctors and nurses. Quantitative data confirmed the validity of these findings, although nurses appeared to have more positive attitudes towards, and to perceive fewer barriers to, the usage of PTTS than were reported by the participating doctors. These findings reveal that non-compliance with PTTS protocol is unlikely to be attributable to negative perceptions of PTTSs. Instead, there are a number of barriers to the implementation of the system. These findings suggest that interprofessional training in PTTSs is essential while increased support for PTTS implementation among senior doctors would also yield improved adherence to protocol. Published by the BMJ Publishing Group Limited. For permission to use (where not already granted under a licence) please go to http://www.bmj.com/company/products-services/rights-and-licensing/

Source: Medline

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

Title: "Deterioration to Door Time": An Exploratory Analysis of Delays in Escalation of Care for Hospitalized Patients.

Citation: Journal of general internal medicine, Aug 2016, vol. 31, no. 8, p. 895-900

Author(s): Sankey, Christopher B, McAvay, Gail, Siner, Jonathan M, Barsky, Carol L, Chaudhry, Sarwat I

Abstract: Timely escalation of care for patients experiencing clinical deterioration in the inpatient setting is challenging. Deterioration on a general floor has been associated with an increased risk of death, and the early period of deterioration may represent a time during which admission to the intensive care unit (ICU) improves survival. Previous studies examining the association between delay from onset of clinical deterioration to ICU transfer and mortality are few in number and were conducted more than 10 years ago. We aimed to evaluate the impact of delays in the escalation of care among clinically deteriorating patients in the current era of inpatient medicine. This was a retrospective cohort study that analyzed data from 793 patients transferred from non-intensive care unit (ICU) inpatient floors to the medical intensive care unit (MICU), from 2011 to 2013 at an urban, tertiary, academic medical center. "Deterioration to door time (DTDT)" was defined as the time between onset of clinical deterioration (as evidenced by the presence of one or more vital sign indicators including respiratory rate, systolic blood pressure, and heart rate) and arrival in the MICU. In our sample, 64.6% had delays in care escalation, defined as greater than 4 h based on previous studies. Mortality was significantly increased beginning at a DTDT of 12.1 h after adjusting for age, gender, and severity of illness. Delays in the escalation of care for clinically deteriorating hospitalized patients remain frequent in the current era of inpatient medicine, and are associated with increased in-hospital mortality. Development of performance measures for the care of clinically deteriorating inpatients remains essential, and timeliness of care escalation deserves further consideration.
**PATIENT SAFETY**

**Title:** Surgical Safety Checklist Associated with Reduced 90-day Mortality  
**Citation:** *JAMA Surg* 2016 Jul 1;151(7):639

**Key points**

- Surgical safety checklists have been shown to reduce in-hospital and 30-day complications and mortality, but their effect on 90-day outcomes is unknown.
- A before-and-after study in Italy evaluating 5,444 patients having noncardiac surgery before the implementation of a surgical safety checklist and 5,297 patients having surgery after high compliance with use of a checklist was reached found a reduction in 90-day mortality during the postintervention period.
- A reduction in 30-day mortality was observed as well, but the result was not statistically significant.

---

**Title:** Patient safety and rocket science  
**Author:** Peter McCulloch  
**Citation:** *BMJ Qual Saf* 2016;25:562-564

**Abstract:**

‘This safety stuff, it's not rocket science’. Many readers of this journal will undoubtedly have heard this sentiment expressed by their clinical colleagues. The article by Kemper et al(1) shows just how widely this impression of patient safety misses the mark. This high-quality study confirms the trend of the recent literature by finding that teamwork training using the civil aviation Crew Resource Management (CRM) approach has no evident clinical benefit, although it does seem to change attitudes and enhance some aspects of the ‘non-technical’ skills involved with interacting with colleagues. In doing so, the study highlights three areas of complexity and challenge in the development and evaluation of safety interventions. First, the interventions themselves are deceptively complex; as recommended by experts, they are grounded in theory,2 but may be entirely wrong. Second, the success of even ‘simple’ interventions like the WHO checklist hugely depends on the context and the implementation strategy. And third, the act of evaluation is far more difficult than it might first appear.

Title: Identifying workflow disruptions in the cardiovascular operating room.

Citation: Anaesthesia, 2016, vol./is. 71/8(948-954)


Abstract: The objectives of this study were to identify the frequency and nature of flow disruptions in the operating room with respect to three cardiac surgical team members: anaesthetists; circulating nurses; and perfusionists. Data collected from 15 cases and coded using a human factors taxonomy identified 878 disruptions. Significant differences were identified in frequency relative to discipline type. Circulating nurses experienced more coordination disruptions ($\chi^2$ (2, $N=110$) = 7.136, $p < 0.028$) and interruptions ($\chi^2$ (2, $N=427$) = 29.743, $p = 0.001$) than anaesthetists and perfusionists, whereas anaesthetists and perfusionists experienced more layout issues than circulating nurses ($\chi^2$ (2, $N=153$) = 48.558, $p = 0.001$). Time to resolve disruptions also varied among disciplines ($\lambda$ (12, 878) = 5.186, $p = 0.000$). Although most investigations take a one-size fits all approach in addressing disruptions to flow, this study demonstrates that targeted interventions must focus on differences with respect to individual role.

Source: CINAHL

---

Title: Can You Multitask? Evidence and Limitations of Task Switching and Multitasking in Emergency Medicine.

Citation: Annals of Emergency Medicine, 2016, vol./is. 68/2(189-195)

Author(s): Skaugset, L. Melissa, Farrell, Susan, Carney, Michele, Wolff, Margaret, Santen, Sally A., Perry, Marcia, Cico, Stephen John

Abstract: Emergency physicians work in a fast-paced environment that is characterized by frequent interruptions and the expectation that they will perform multiple tasks efficiently and without error while maintaining oversight of the entire emergency department. However, there is a lack of definition and understanding of the behaviors that constitute effective task switching and multitasking, as well as how to improve these skills. This article reviews the literature on task switching and multitasking in a variety of disciplines-including cognitive science, human factors engineering, business, and medicine-to define and describe the successful performance of task switching and multitasking in emergency medicine. Multitasking, defined as the performance of two tasks simultaneously, is not possible except when behaviors become completely automatic; instead, physicians rapidly switch between small tasks. This task switching causes disruption in the primary task and may contribute to error. A framework is described to enhance the understanding and practice of these behaviors.

Source: CINAHL
Title: A review of patient safety incidents reported as 'severe' or 'death' from critical care units in England and Wales between 2004 and 2014.

Citation: Anaesthesia, 2016, vol./is. 71/9(1013-1023)

Author(s): Thomas, A. N., MacDonald, J. J.

Abstract: We analysed 1743 patient safety incidents reported between 2004 and 2014 from critical care units in England and Wales where the harm had been classified as 'severe' (1346, 77%) or 'death' (397, 23%). We classified 593 (34%) of these incidents as resulting in temporary harm, and 782 (45%) as more than temporary harm, of which 389 (22%) may have contributed to the patient's death. We found no described harm in 368 (21%) incidents. We classified 1555 (89%) of the incidents as being avoidable or potentially avoidable. There were changes over time for some incident types (pressure sores: 10 incidents in 2007, 64 in 2012; infections: 60 incidents in 2007, 10 in 2012) and some changes in response to national guidance. We made a comparison with a dataset of all incidents reported from units in North-West England, and this confirmed that the search strategy identified more severe incidents, but did not identify all incidents that contributed to mortality.

Source: CINAHL

Title: Patient safety climate strength: a concept that requires more attention.

Citation: BMJ Quality & Safety, 2016, vol./is. 25/9(680-688)

Author(s): Ginsburg, Liane, Oore, Debra Gilin

Source: CINAHL

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

Title: Improving Safety for Hospitalized Patients: Much Progress but Many Challenges Remain.

Citation: JAMA: Journal of the American Medical Association, 2016, vol./is. 316/5(489-490)

Author(s): Kronick, Richard, Arnold, Sharon, Brady, Jeffrey

Abstract: The article examines the safety milestones achieved in the care of hospital patients in the U.S. along with the challenges for the future. Topics discussed include the harms listed in the Medicare Patient Safety Monitoring System (MPSMS), the usual catheter-associated urinary tract infections (CAUTIs) or central line-associated blood stream infections and the statistical report from the Agency for Healthcare Research and Quality (AHRQ). Also mentioned are diagnostic errors and record reviews.
**Title:** At a crossroads? Key challenges and future opportunities for patient involvement in patient safety.

**Citation:** BMJ Quality & Safety, 2016, vol./is. 25/8(565-568)

**Author(s):** O'Hara, Jane K., Lawton, Rebecca J.

**Source:** CINAHL

**Abstract:**
Expense, efficiency of use, learning curves, workflow integration and an increased prevalence of serious incidents can all be barriers to adoption. We explored an observational approach and initial diagnostics to enhance total system performance in robotic surgery. Eighty-nine robotic surgical cases were observed in multiple operating rooms using two different surgical robots (the S and Si), across several specialties (Urology, Gynecology, and Cardiac Surgery). The main measures were operative duration and rate of flow disruptions—described as 'deviations from the natural progression of an operation thereby potentially compromising safety or efficiency.' Contextual parameters collected were surgeon experience level and training, type of surgery, the model of robot and patient factors. Observations were conducted across four operative phases (operating room pre-incision; robot docking; main surgical intervention; post-console). A mean of 9.62 flow disruptions per hour (95% CI 8.78-10.46) were predominantly caused by coordination, communication, equipment and training problems. Operative duration and flow disruption rate varied with surgeon experience (p = 0.039; p < 0.001, respectively), training cases (p = 0.012; p = 0.007) and surgical type (both p < 0.001). Flow disruption rates in some phases were also sensitive to the robot model and patient characteristics. Flow disruption rate is sensitive to system context and generates improvement diagnostics. Complex surgical robotic equipment increases opportunities for technological failures, increases communication requirements for the whole team, and can reduce the ability to maintain vision in the operative field. These data suggest specific opportunities to reduce the training costs and the learning curve.

**Source:** Medline
Title: Developing a coaching mechanism for practicing surgeons.

Citation: Surgery, Sep 2016, vol. 160, no. 3, p. 536-545

Author(s): Stefanidis, Dimitrios, Anderson-Montoya, Brittany, Higgins, Robert V, Pimentel, Manuel E, Rowland, Patrick, Scarborough, Madison O, Higgins, Danelle

Abstract: While performance feedback and assessment are hallmarks of surgical training, they abruptly cease after training is completed. In their absence, performance may stagnate and poor habits persist. Our aim was to develop a coaching mechanism for practicing surgeons with feedback provision based on objective performance assessment. Technical and nontechnical intraoperative video recordings from laparoscopic or robotic cholecystectomies, colectomies, and hysterectomies were assessed by a blinded surgeon and a human factors expert, respectively. Aspects of performance in need of improvement were noted, and a coaching session was developed for feedback provision to participating surgeons. This 4-hour coaching session consisted of a didactic lecture with video review and hands-on practice using procedural and mannequin-based simulation. Thirty-two practicing surgeons (18 general; 14 gynecologists) from 6 different hospitals were assessed, and 9 of them participated in coaching. Technical aspects identified for performance improvement included suboptimal trocar placement, inadequate critical view achievement during laparoscopic cholecystectomies, poor visualization of the operating field, bimanual dexterity, and dissection techniques, while nontechnical aspects included inappropriate handling of distractions and interruptions, poor ergonomic positioning and situational awareness, and inadequate mitigation of delays. Most surgeons appropriately accomplished some of the objectives of the distraction scenario, but none was able to achieve expert levels on Fundamentals of Laparoscopy tasks. Participants perceived the coaching sessions as highly valuable. Our study identified several technical and nontechnical skill sets of practicing surgeons in need of improvement and provided support for the implementation of coaching programs for surgeons on an ongoing basis. Copyright © 2016 Elsevier Inc. All rights reserved.

Source: Medline


Citation: JAMA ophthalmology, Aug 2016, vol. 134, no. 8, p. 905-911

Author(s): Saleh, George M, Wawrzynski, James R, Saha, Kamran, Smith, Phillip, Flanagan, Declan, Hingorani, Melanie, John, Clinton, Sullivan, Paul

Abstract: Human factors training can enhance teamworking and reduce error. It is used regularly in certain medical disciplines, but its use has not been established for ophthalmology to our knowledge. To explore the feasibility of providing immersive simulation human factors training for ophthalmic surgical teams. Prospective scenario-based simulation and concept description at University College London Hospital and Moorfields
Eye Hospital, London, England, from December 12, 2013, to March 13, 2014. At both sites, fully immersive simulated operating theater environments were used, comprising live interactive communication with patients and theater staff, full anesthetic and operating facilities, replicated patient notes, active vital signs, and the ability to contact surgical or anesthetic teams outside of the theater via telephone. Participants were consultant (attending) and trainee ophthalmic surgeons and anesthetists, operating department assistants and practitioners, and ophthalmic nursing staff. The following 4 previously validated rating tools for nontechnical skills were applied to a replicated series of scenarios based on actual patient safety incidents at Moorfields Eye Hospital and in the literature: Observational Teamwork Assessment for Surgery (OTAS), Non-Technical Skills Scale (NOTECHS), Anesthetists’ Non-Technical Skills (ANTS), and Non-Technical Skills for Surgeons (NOTSS). The Pearson product moment correlation coefficient was calculated for each pair of scoring tools. Intertool and interassessor reliability was established. Interassessor consistency was compared by calculating a normalized standard deviation of scores for each tool across all assessors. Twenty simulation scenarios, including wrong intraocular lens implantation, wrong eye operation, wrong drug administration, and wrong patient, were provided. The intertool correlations were 0.732 (95% CI, 0.271-0.919; P = .01) for NOTECHS vs ANTS, 0.922 (95% CI, 0.814-0.968; P < .001) for NOTSS vs ANTS, 0.850 (95% CI, 0.475-0.964; P < .001) for OTAS vs ANTS, 0.812 (95% CI, 0.153-0.971; P = .03) for OTAS vs NOTECHS, 0.716 (95% CI, -0.079 to 0.955; P = .07) for OTAS vs NOTSS, and 0.516 (95% CI, -0.020 to 0.822; P = .06) for NOTECHS vs NOTSS. The normalized standard deviations of scores obtained using each tool across all assessors were 0.024 (95% CI, 0.014-0.091) for NOTSS, 0.060 (95% CI, 0.034-0.225) for OTAS, 0.068 (95% CI, 0.041-0.194) for ANTS, and 0.072 (95% CI, 0.043-0.206) for NOTECHS. This study describes the feasibility of a high-fidelity immersive simulation course specifically for ophthalmic surgical teams. The ANTS and NOTSS had the highest intertool and interrater consistency, respectively. Human factors simulation in ophthalmology offers a new method of teaching team members, with the potential to reduce serious ophthalmic patient safety events. Further work will define its usefulness and practical applications.

Source: Medline

Title: Examining the effects of an interprofessional crew resource management training intervention on perceptions of patient safety.

Citation: Journal of interprofessional care, Jul 2016, vol. 30, no. 4, p. 536-538


Abstract: This article reports the results from a study that employed an interprofessional crew resource management (CRM) education programme in the emergency and critical care departments. The study aimed to investigate the effectiveness of this intervention of participants’ satisfaction and safety attitude changes using a satisfaction questionnaire and the Human Factors Attitude Survey (HFAS). Overall, participants responded positively to the CRM training-93.4% were satisfied, 93.1% agreed that it enhanced patient safety and care quality, 85.7% agreed that it increased their confidence, 86.4% agreed that it reduced practice
errors, and 90.8% agreed that it would change their behaviours. Overall, the participants reported positive changes in their attitudes regarding 22 of the 23 HFAS questions.

Source: Medline

---

**Title:** Identifying workflow disruptions in the cardiovascular operating room.

**Citation:** Anaesthesia, 2016, vol./is. 71/8(948-954)


**Abstract:** The objectives of this study were to identify the frequency and nature of flow disruptions in the operating room with respect to three cardiac surgical team members: anaesthetists; circulating nurses; and perfusionists. Data collected from 15 cases and coded using a human factors taxonomy identified 878 disruptions. Significant differences were identified in frequency relative to discipline type. Circulating nurses experienced more coordination disruptions ($\chi^2 (2, N = 110) = 7.136, p < 0.028$) and interruptions ($\chi^2 (2, N = 427) = 29.743, p = 0.001$) than anaesthetists and perfusionists, whereas anaesthetists and perfusionists experienced more layout issues than circulating nurses ($\chi^2 (2, N = 153) = 48.558, p = 0.001$). Time to resolve disruptions also varied among disciplines ($\lambda (12, 878) = 5.186, p = 0.000$). Although most investigations take a one-size fits all approach in addressing disruptions to flow, this study demonstrates that targeted interventions must focus on differences with respect to individual role.

Source: CINAHL

---

**Title:** Can You Multitask? Evidence and Limitations of Task Switching and Multitasking in Emergency Medicine.

**Citation:** Annals of Emergency Medicine, 2016, vol./is. 68/2(189-195)

**Author(s):** Skaugset, L. Melissa, Farrell, Susan, Carney, Michele, Wolff, Margaret, Santen, Sally A., Perry, Marcia, Cico, Stephen John

**Abstract:** Emergency physicians work in a fast-paced environment that is characterized by frequent interruptions and the expectation that they will perform multiple tasks efficiently and without error while maintaining oversight of the entire emergency department. However, there is a lack of definition and understanding of the behaviors that constitute effective task switching and multitasking, as well as how to improve these skills. This article reviews the literature on task switching and multitasking in a variety of disciplines-including cognitive science, human factors engineering, business, and medicine-to define and describe the successful performance of task switching and multitasking in emergency medicine. Multitasking, defined as the performance of two tasks simultaneously, is not possible except when behaviors become completely automatic; instead, physicians rapidly switch between small tasks. This task switching causes disruption in the primary task and may contribute to...
error. A framework is described to enhance the understanding and practice of these behaviors.

**Source:** CINAHL
If you are unable to find a book, or require a book that is not on this list, please ask library staff who will be able to locate the book for you using interlibrary loan.

The following book was recommended at the SW Academic Health Science Network

*Quality Improvement in Action in the South West Study Day*, June 2016

**Chip Heath and Dan Heath (2010)**

*Switch: how to change things when change is hard*

Why is it so hard to make change happen? In ‘Switch’, authors Chip and Dan Heath argue that the reason lies deep within our psychology as they outline the best ways to make changes not only in our own lives, but also in the lives of others.

We now have a subscription to EBL Electronic Books and would be interested to know if there are any titles you feel would be of benefit to be added to our collection. The catalogue can be browsed [here](#); you will need your OpenAthens password to access it. You can request books either on the site itself or by emailing us on [library@tst.nhs.uk](mailto:library@tst.nhs.uk)
**UpToDate**

Access is available to MPH staff only but topics from UpToDate can be supplied to Sompar staff on request. OpenAthens password required.

- **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.

**Dynamed Plus**

Access is available to Sompar staff only but topics from UpToDate can be supplied to MPH staff on request. Open Athens password required.

- **Falls in the elderly**
- **Pressure ulcer**
- **Sepsis in adults**
- **Sepsis treatment in adults**

Please contact library staff for details on how to access this resource; you will need an Athens password if accessing from home.
Maternity pressure ulcers legal leaflet
As part of a series of leaflets aimed at reducing preventable injuries, the NHS Litigation Authority has published Did you know? Maternity pressure ulcers. Maternity pressure ulcers have resulted in 39 claims from women in the five years from April 2009. The leaflet pinpoints factors that were common to the care the women received and highlights the cost of compensating patients affected by poor care.

Learning from mistakes
An investigation report by the Parliamentary and Health Service Ombudsman into how the NHS failed to properly investigate the death of a three-year old child


Patient Led Reviews – giving patients / citizens the option to project manage their own care
This novel approach involves people reviewing their treatments, care and medicines in a 3/4 hour session with two health professionals. The health professionals keep no notes and concentrate on providing the people with their own notes in the form of a written list of things to check out.

They also give advice on trusted sources of information, and on questions to ask their doctors.

Benefits identified to date include improved adherence with medicines; improved quality of life; reduced unnecessary medicines; identification and actions on previously unreported patient safety issues; a potential reduction in ‘bouncing’ referrals, less missing information and fewer unnecessary contacts with services.

Read more at:
http://fabnhsstuff.net/2016/08/03/patient-led-reviews-giving-patients-citizens-option-project-manage-care/
Sign up to safety : Patient safety resources

This site includes patient safety and quality improvement websites that are useful for evidence, information, latest news, research and examples of other international campaigns.

https://www.england.nhs.uk/signuptosafety/ps-res/

UK Sepsis Trust: Professional resources

Includes resources like the Sepsis six tool

http://sepsistrust.org/professional/professional-resources/

Resources for the detection and management of deterioration in adult patients

Shared learning resources from NHS Improvement.

https://improvement.nhs.uk/resources/detection-and-management-deterioration-adult-patients/

The Health Foundation: Patient safety Resource Centre

This Resource Centre covers four main areas of Patient Safety

- Safety Management
- Frail Older People
- Diabetes
- Maternity

http://patientsafety.health.org.uk/
NICE “Do Not Do” : Patient Safety, Savings and Productivity

Identify clinical practice that should be discontinued or not used routinely.

Each one contains information on the healthcare setting and links to the relevant NICE guidance or Quality Standard.


---

Film puts spotlight on recognising signs of sepsis in children

A new film which aims to help healthcare professionals to spot and respond to the warning signs of sepsis in children is being launched today.

The short film features the story of Jason and Clara Watkins who tragically lost their daughter Maude aged just three to undiagnosed Sepsis in 2011. The couple share their own personal experiences about the events which led up to the sad loss of their daughter.

Read more at:


To view the film and find out more about the e-learning materials visit

www.hee.nhs.uk/sepsisawareness
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.