Patient Safety Bulletin February 2020

Articles

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A systematic review exploring the content and outcomes of interventions to improve psychological safety, speaking up and voice behaviour.
[This review synthesises the content, theoretical underpinnings and outcomes of interventions which have targeted psychological safety, speaking up, and voice behaviour within a healthcare setting. It aims to identify successful interventions and inform the development of more effective interventions.]

Comparative value of a simulation by gaming and a traditional teaching method to improve clinical reasoning skills necessary to detect patient deterioration: a randomized study in nursing students.
[Early detection and response to patient deterioration influence patient prognosis. Nursing education is therefore essential. The objective of this randomized controlled trial was to compare the respective educational value of simulation by gaming (SG) and a traditional teaching (TT) method to improve clinical reasoning (CR) skills necessary to detect patient deterioration.]

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Development and implementation of a standardised emergency department intershift handover tool to improve physician communication.
[Conclusions: We achieved sustained improvements in the amount of information communicated during physician emergency department (ED) handovers using established quality improvement (QI) methodologies. Engaging stakeholders in handover tool customisation for local context was an important success factor. We believe this approach can be easily adopted by any ED.]

Failure of vital sign normalization is more strongly associated than single measures with mortality and outcomes.
[ Dynamic vital signs in the emergency department, as categorized by delta MEWS, and failure to normalize abnormalities, were associated with increased mortality, ICU admission, LOS, and the diagnosis of sepsis. Our results suggest that MEWS scores that do not normalize, from triage onward, are more strongly associated with outcome than any single score.]

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How does the WHO Surgical Safety Checklist fit with existing perioperative risk management strategies? An ethnographic study across surgical specialties.
[This study aimed to explore how members of the multidisciplinary perioperative team integrate the SSC within their risk management strategies. When the SSC is not integrated within existing risk management strategies, but perceived as an "add on", its fidelity is compromised, hence limiting its potential clinical effectiveness. Implementation strategies for the SSC should thus integrate it as a risk-management tool and include it as part of risk-management education and training.]

Portable nursing stations reduce the rate of inpatient falls in UK hospitals.
Haghgoshayie E. Evidence-Based Nursing 2020;23(1):29.
[Overall, 2875 inpatient falls were identified, and 17 wards participated between April 2014 and December 2017. The fallers' mean age was 78±13. Fifty-eight per cent of participants were men. Most falls, 99.41%, resulted in none, slight or moderate harm, 0.45% in severe harm and 0.14% in death. The falls rate monthly increased by 0.119 per 1000 OBDs (p Available with an NHS OpenAthens password

Prevention strategies to identify LASA errors: building and sustaining a culture of patient safety.
[Potential look-alike, sound-alike (LASA) errors in outpatient and inpatient prescriptions have been widely described worldwide. However, most strategies of reducing drug name confusion have been only focused on the processes of prescribing and dispensing, often following local rules. The implication of authorities in toptdown strategies and the importance of developing an international health policy on the authorization of unique names for innovative medicines are highlighted.]

Sitters as a Patient Safety Strategy to Reduce Hospital Falls: A Systematic Review.
[Bedside "sitters" are often used for patients at high risk for falls, but they are expensive and their effectiveness is unclear. Of 20 studies meeting inclusion criteria, 2 added sitters to usual care and 18 compared alternatives to sitters. Despite a compelling rationale, evidence is scant that adding sitters to usual care reduces falls.] Available with an NHS OpenAthens password for eligible users

Unpacking organizational readiness for change: an updated systematic review and content analysis of assessments.
[Organizational readiness assessments have a history of being developed as important support tools for successful implementation. However, it remains unclear how best to operationalize readiness across varied projects or settings. We conducted a synthesis and content analysis of published readiness instruments to compare how investigators have operationalized the concept of organizational readiness for change.]
What do we really assess with organisational culture tools in healthcare? An interpretive systematic umbrella review of tools in healthcare.
[A toxic organisational culture (OC) is a major contributing factor to serious failings in healthcare delivery. Conclusion: This umbrella review identifies the essential tangible and intangible themes of OC tools. OC tools in healthcare do not seem to be designed to determine deeper underlying dimensions of culture. We suggest approaching complex underlying OC problems by focusing on the intangible dimensions, rather than putting the tangible dimensions up front.]

Repsorts

*The following report(s) may be of interest:*

**Corridor Care: Survey Results.**
Royal College of Nursing (RCN); 2020.
https://www.rcn.org.uk/professional-development/publications/pub-009150
[This document records the findings of an online survey sent to 7,106 members of the RCN's Emergency Care Association network exploring their experiences of corridor care.]
*Freely available online*

**Report of the Independent Inquiry into the Issues raised by Paterson.**
Department of Health and Social Care (DHSC); 2020.
[A report from the independent inquiry that was set up following the conviction of surgeon Ian Paterson.]
*Freely available online*
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