Ophthalmology March 2020

Articles

A new instrument to measure high value, cost-conscious care attitudes among healthcare stakeholders: development of the MHAQ.
[This study was carried out to develop an instrument to reliably measure high value, cost-conscious care (HVCCC) attitudes among residents, staff physicians, administrators, and patients. The instrument can be used to assess the residency-training environment.] **Contact the library for a copy**

Application of human factors to improve usability of clinical decision support for diagnostic decision-making: a scenario-based simulation study.
[Conclusions: This simulation study shows that human factors (HF) methods and principles can improve usability of clinical decision support (CDS) and diagnostic decision-making. Aspects of the HF-based CDS that provided cognitive support to emergency physicians and improved diagnostic performance included automation of information acquisition, minimisation of workload and support of decision selection...] **Contact the library for a copy**

Characteristics of successful changes in health care organizations: an interview study with physicians, registered nurses and assistant nurses.
[The aim was to investigate the characteristics of changes of relevance for the work of health care professionals that they deemed successful. Organizational changes in health care are more likely to succeed when health care professionals have the opportunity to influence the change, feel prepared for the change and recognize the value of the change, including perceiving the benefit of the change for patients.] **Contact the library for a copy**

**Considering the ‘ostrich syndrome’ and patient safety.**
[The author discusses two patient safety reports, which stress the importance of taking proper action when patient safety incidents occur. The NHS is littered with examples of cases where individuals and organisations have seemingly buried their heads in the sand when patient safety errors have occurred. Attitudes range from refusing to take responsibility, assuming that another organisation is dealing with the matter, delaying a response or even ignoring the situation completely.]
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Detecting Patient Deterioration Using Artificial Intelligence in a Rapid Response System.
[The developed artificial intelligence based on deep-learning, deep learning-based early warning system, accurately predicted deterioration of patients in a general ward and outperformed conventional methods. This study showed the potential and effectiveness of artificial intelligence in an rapid response system, which can be applied together with electronic health records. This will be
a useful method to identify patients with deterioration and help with decision-making in daily practice.] Contact the library for a copy

**Effect of an educational programme on the attitudes towards patient safety of operation room nurses.**


[A culture of patient safety is one of the cornerstones of good-quality healthcare, and its provision is one of the significant challenges in healthcare environments. The purpose of this study was to evaluate the effect of a surgical safety educational programme on the attitudes of nurses to patient safety in operating rooms (OR).]

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**Identifying adverse events: reflections on an imperfect gold standard after 20 years of patient safety research.** [Editorial]


["...Generating broad interest in patient safety required an easily understood measure to demonstrate the scope of preventable harms caused by the healthcare system. Few would question that scope now. To make progress in this now well-established field, we need measures tailored to specific patient harms. No other field attempts to measure progress in the form of an omnibus measure...."] Contact the library for a copy

**Is patient safety in the NHS in England a postcode lottery?**


[The author discusses some recent patient safety publications from the World Health Organization and the Care Quality Commission. On a flight, there is generally no doubt in passengers’ minds that they will arrive safely at their destination—air accidents are extremely rare. However, when it comes to healthcare treatment it is difficult to have the same level of confidence in outcome. The World Health Organization (WHO) has published a ‘fact file’ on patient safety.]

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**Measuring safety of healthcare: an exercise in futility?** [Viewpoint]


["...We assert that these efforts should continue because absence of proof of benefit from adverse event detection and reporting does not equate to proof of absence of benefit. Despite the famous quote on insanity, it is not insane to keep trying. There is merit to soldiering on in our attempts to produce evidence and data to inform our pursuit of safer care for all."] Contact the library for a copy

**Patient safety reports and crisis events round up.**


[The author discusses some recent patient reports and crisis events. There is a famous quote attributed a former Prime Minister, Harold Wilson, that ‘a week is a long time in politics’. A lot can happen in a week politically and the same can be said about patient safety in the NHS. Recently the media spotlight has turned yet again on some poor NHS care practices in maternity care, following the publication of the Care Quality Commission’s (CQC) survey findings.]

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Pre-registration nursing students’ perceptions and experience of intentional rounding: a cross-sectional study.
(This paper examines pre-registration nursing students’ perceptions of the practice of intentional rounding and perceived benefits for nurses and patients. Intentional rounding was developed to ensure nursing staff regularly check on patients to ensure that all care needs are met. It has been linked to a reduction in falls and call bell use, and an increase in patient safety.)
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[Conclusions: Through implementation, we found that a hospital-wide mortality review process that elicits feedback from front-line providers is feasible, and provides valuable insights regarding potential preventable mortality and prioritising actionable opportunities for care delivery improvements.] Contact the library for a copy

Study of a multisite prospective adverse event surveillance system.
[Conclusion: This study demonstrated that it is possible to implement prospective surveillance in different settings. Such surveillance appears to be better suited to evaluating hospital safety concerns within rather than between hospitals as we could not definitively rule out whether the observed variation in AE risk was due to population or surveillance factors.] Contact the library for a copy

Understanding complaints.
[The author considers how the complaints from patients and staff have changed over the years and how a decision-making tool has helped her consider the issues. A chief nurse post typically has the remit of both the leadership of the Trust's Patient Advice and Liaison Service (PALS) and complaints teams, in addition to the professional leadership of registrants. Over the past decade, the issues that have been reported to me for decisions have changed.] Available with an NHS OpenAthens password for eligible users

Use of Fall Risk–Increasing Drugs Around a Fall-Related Injury in Older Adults: A Systematic Review.
[Limitied evidence indicates high prevalence of FRID use among older adults who have experienced a fall-related injury and no reduction in overall FRID use following the fall-related healthcare encounter. There is a need for well-designed interventions to reduce FRID use and falls in older adults with a history of falls. Reducing FRID use as a stand-alone intervention may not be effective in reducing recurrent falls.] Freely available online
Report

**TUC Safety Valve to prevent balloon inflation in the urethra during transurethral catheterisation.**
National Institute for Health and Care Excellence (NICE); 2020.
https://www.nice.org.uk/advice/mib210

[NICE has developed a medtech innovation briefing (MIB) on TUC Safety Valve to prevent balloon inflation in the urethra during transurethral catheterisation. The device is claimed to be the only one on the market that prevents accidental inflation of the catheter in the urethra. It could improve standard care by avoiding urethra trauma and complications from it such as urethral bleeding, urethral stricture disease, and, in some cases, death.]
*Freely available online*

Guideline

**Guidance on Prescribing, Dispensing, Supplying and Administration of Medicines.**
Royal College of Nursing (RCN) & Royal Pharmaceutical Society; 2020.
https://www.rcn.org.uk/professional-development/publications/pub-009013

[This publication provides information on the Royal College of Nursing and Royal Pharmaceutical Society’s position on the prescribing, dispensing, supplying and administration of medicines.]
*Freely available online*

**ICU admission decision support tool showed promise but was rarely used.**
NIHR Dissemination Centre; 2020.
https://discover.dc.nihr.ac.uk/content/signal-000882/icu-admission-decision-support-tool-showed-promise-but-was-rarely-used

[NIHR Signal. A decision support tool developed to help doctors determine whether patients should be admitted to intensive care showed promise in facilitating patient-clinician communication, but was not often used by doctors, with fewer than 30% using the forms.]
*Freely available online*

**Structured nurse ward rounds support accountability and risk management but not nurse-patient communication.**
NIHR Dissemination Centre; 2020.
https://discover.dc.nihr.ac.uk/content/signal-000886/structured-nurse-ward-rounds-bring-mixed-outcomes

[NIHR Signal. Intentional rounding was introduced as a UK Government policy imperative to facilitate regular interactions between nurses and patients following high profile care failures at the Mid Staffordshire NHS Foundation Trust. However, this NIHR-funded mixed-methods study suggests that intentional rounding may result in more brief task-orientated nurse-patient interactions rather than better quality interactions tailored to patient needs.]
This Bulletin was created by Liz Wright of NHS East Dorset Knowledge and Library Service

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