Patient Safety Together:
learning, sharing and improving

Review Period: Feb - May 2024

HSE Patient Safety Digest

This *HSE Patient Safety Digest* contains journal articles, reports and information relating to patient safety.

The content was sourced by the HSE Health Library Ireland Services and the HPRA in collaboration with the HSE National Quality and Patient Safety Directorate – Incident Management Team.

QPSIM-PST 016

Leabharlann Sláinte na hÉireann
Health Library Ireland
Ár nAcmhainn Náisiúnta | Our National Resource

HPRA
An tÚdarás Rialála Táirgí Sláinte
Health Products Regulatory Authority

An Stiúrthóireacht um Ardchaighdeáin agus Sábháilteacht Othar
Oifig an Phríomhoifigigh Cliniciúil
National Quality and Patient Safety Directorate
Office of the Chief Clinical Officer

This edition of the HSE Patient Safety Digest includes a collection of 13 articles (Section 1, pgs. 1-6) and two reports/webpages (Section 2 pg. 6) that relate to quality and patient safety. They are sourced from high quality, national and international peer-reviewed periodicals. Section 3 (pg.7) includes three recently published Direct Healthcare Professional Communications (DHPC) containing important new medicine safety information approved by the Health Products Regulatory Authority (HPRA).

The information and learning shared in these publications are relevant to anyone with an interest in improving patient safety in our health services.

Section 1: Journal Articles

Article Title	Author	Date of Publication	Details of Abstract	Publication Source
Theme: Human Factors				
Exploring the impact of compassion and leadership on patient safety and quality in healthcare systems: a narrative review	Ahmed Z. et al	May 2024	**Background** Patient safety and healthcare quality (PS&Q) are considered integral parts of the healthcare system that are driven by a dynamic combination of human and non-human factors. This review article provides an insight into the two major human factors that impact PS&Q including compassion and leadership…In addition, this review also provides strategies for the improvement of PS&Q through compassion and effective leadership. **Methods** This narrative review explores the existing literature on compassion and leadership and their combined impact on PS&Q…..**Results** The findings from the literature suggest that both compassion and transformational leadership can create a positive culture where healthcare professionals (HCPs) prioritise PS&Q... **Conclusion** Compassion can become an antidote for the burnout of HCPs... Both compassionate care and transformational leadership improve organisational culture, patient experience, patient engagement, outcomes and overall healthcare excellence...	https://bmjopenquality.bmj.com/content/13/Suppl_2/e002651
A systematic review of workplace triggers of emotions in the healthcare environment, the emotions experienced, and the impact on patient safety	Raabia S. et al	May 2024	**Background** Healthcare staff deliver patient care in emotionally charged settings and experience a wide range of emotions as part of their work. These emotions and emotional contexts can impact the quality and safety of care. Despite the growing acknowledgement of the important role of emotion, we know very little about what triggers emotion within healthcare environments or the impact this has on patient safety… **Methods** … four electronic databases were searched …... **Results** In stage 1, 90 studies were included from which seven categories of triggers of emotions in the healthcare work environment were identified, namely: patient and family factors, patient safety events and their repercussions, workplace toxicity, traumatic events, work overload, team working and lack of supervisory support.... **Conclusion** The various triggers of emotion and the types of emotion experienced that have been identified in this review can be used as a framework for further work examining the role of emotion in patient safety….	https://bmchealthservres.biomedcentral.com/articles/10.1186/s12913-024-11011-1

Theme: Incident Management				
Patients' perspectives on quality and patient safety failures: lessons learned from an inquiry into transvaginal mesh in Australia	Motamedi M. et al	April 2024	**Background** Transvaginal mesh (TVM) surgeries emerged as an innovative treatment for stress urine incontinency and/or pelvic organ prolapse in 1996. Years after rapid adoption of these surgeries into practice, they are a key example of worldwide failure of healthcare quality and patient safety. The prevalence of TVM-associated harms eventually prompted action globally, including an Australian Commonwealth Government Senate Inquiry in 2017. **Method** The authors analysed 425 submissions made by women (n = 417) and their advocates (n = 8) to the Australian Senate Inquiry, and documents from 5 public hearings… They focused on women's accounts of: a) how harms arose from TVM procedures, and b) micro, meso and macro factors that contributed to their experience… **Results** Findings suggest three mechanisms explaining quality and safety failure: 1. Individual clinicians could ignore cases of TVM injury or define them as 'non-preventable'; 2. Women could not go beyond their treating clinicians to participate in defining and governing quality and safety; and. 3. Health services set thresholds for concern based on proportion of cases harmed, not absolute number or severity of harms. **Conclusion** The authors argue that privileging clinical perspectives over patient perspectives in evaluating TVM outcomes allowed micro-level actors to dismiss women's lived experience…. Establishing system-wide expectations regarding responsiveness to patients, and communication of patient reported outcomes in evaluation of healthcare delivery, may help prevent similar failures.	https://bmchealthservres.biomedcentral.com/articles/10.1186/s12913-024-10791-w
Updating Eindhoven: Clarifying the features of a patient safety near miss	Woodier N. et al	April 2024	**Background** There are benefits to healthcare from reporting and learning from near misses in patient care. However, there have been longstanding issues with identifying near misses, with variation in definitions. Learning is being lost, unlike in other industries that have harnessed their learning potential. The features of a healthcare near miss have never been described nor modelled. This study aimed to identify those features to support near-miss identification, reporting and learning. **Methods** This study took a mixed-methods approach with participants from healthcare and four high-reliability industries – aviation, maritime, nuclear and rail... **Results** Participants from 17 healthcare and 35 industry organisations took part. Quantitative findings demonstrated variation in agreement of the features of a near miss… Qualitative findings identified the following themes in relation to the features of a near miss – context dependent, involve control, are complex and represent vulnerabilities….several industries have lists of specific situations that constitute near misses that support reporting and focus. **Conclusion** Without clear agreement of the features of a healthcare near miss, definitions will continue to vary. This study has, for the first time, provided exploration and clarification of the features of a near miss with the offer of a healthcare model for future validation. Without addressing the fundamentals, such as agreeing what a near miss is, healthcare cannot hope to learn from them.	https://journals.sagepub.com/doi/10.1177/25160435241247096

Theme: Patient Focused				
Conceptualizing and redefining successful patient engagement in patient advisory councils in learning health networks	Huwe M, et al	June 2023	**Introduction** Patient engagement has historically referenced engagement in one's healthcare, with more recent definitions expanding patient engagement to encompass patient advocacy work in Learning Health Networks (LHNs). Efforts to conceptualize and define what patient engagement means—and what successful patient engagement means—are, however, lacking and a barrier to meaningful and sustainable patient engagement via patient advisory councils (PACs) across LHNs. **Methods** Several co-authors are former ImproveCareNow (ICN) PAC members, and integrate a narrative review of the extant literature and a case study of lived experiences as former ICN PAC members…..**Results** … successful patient/PAC engagement experiences with ICN represent key mechanisms that could be applied across LHNs, including (1) personal growth for PAC members, (2) PAC internal engagement/community, (3) PAC engagement and presence within the LHN, (4) local institutional engagement for those who participate in the LHN, and (5) tangible resources/products from PAC members. **Conclusion** Patient engagement in LHNs, like ICN, holds significant power to meaningfully shape and co-produce healthcare systems, and engagement is undervalued and conceptualized dichotomously (eg, engaged or not engaged)….	https://onlinelibrary.wiley.com/doi/full/10.1002/lrh2.10377
How Healthcare Organizations are Implementing Disability Accommodations for Effective Communication: A Qualitative Study	Oshita JY. et al	May 2024	**Background** Prior studies have documented that, despite federal mandates, clinicians infrequently provide accommodations which enable equitable healthcare engagement for patients with communication disabilities. To date, there has been a paucity of empirical research describing the organizational approach to implementing these accommodations. The authors asked US healthcare organizations how they were delivering these accommodations in the context of clinical care, what communication accommodations they provided, and what disability populations they addressed. **Methods** 19 qualitative interviews were performed with disability coordinators…The authors used a conventional qualitative content analysis approach to code the data and derive themes. **Results** The authors identified three major themes related to how US healthcare organizations are implementing the provision of this service: (1) operationalizing the delivery of communication accommodations in healthcare required executive leadership support and preparatory work at clinic and organization-levels; (2) the primary focus of communication accommodations was sign language interpreter services for Deaf patients and, secondarily, other hearing- and visual-related accommodations; and (3) providing communication accommodations for patients with speech, language, and cognitive disabilities was less frequent, but when done involved more than providing a single aid or service. **Conclusions** … in addition to individual clinician efforts, there are organization-level factors that impact consistent provision of communication accommodations across the full range of communication disabilities. Future research should investigate these factors and test targeted implementation strategies to promote equitable access to healthcare for all patients with communication disabilities.	https://www.sciencedirect.com/science/article/abs/pii/S1553725024001442

Theme: After Action Review				
Applying the theoretical domains framework to identify enablers and barriers to after action review: An analysis of implementation in an Irish tertiary specialist hospital	Finn M. et al	2024	**Background** After Action Review (AAR) is a debriefing methodology for learning from events. The method is a facilitated discussion among a team exploring what they expected to happen, what did happen, and what they learned. Ireland's HSE includes the AAR methodology as part of its national Incident Management Framework. This paper explores enablers and barriers to AAR implementation in an Irish tertiary specialist hospital. **Methods** Fifty staff were trained as AAR facilitators in a 1.5 day simulation training programme. Six months after training, focus group discussions explored facilitator perceptions of enablers and barriers to AAR implementation. Framework analysis was applied to the data, informed by the Theoretical Domains Framework. **Results** Four focus group discussions with 14 AAR facilitators were conducted. Seven enablers, twelve barriers and eight enablers/barriers were identified across all 14 TDF domains. Three domains of reinforcement; professional role and identity; and emotion contained the richest data on processes acting as enablers and barriers to AAR implementation. **Conclusion** To promote implementation of AAR, practical experience must be reinforced in the aftermath of training; professional position in teams and units must be considered in initiating and facilitating AAR; and staff emotions around facilitation must be supported as enablers through practice and skill development.	https://www.sciencedirect.com/science/article/pii/S0925753524000791
Theme: Patient Safety				
Pay-for-performance and patient safety in acute care: A systematic review	Slawomirski L. et al	May 2024	Background Pay-for-performance (p4p) has been tried in all healthcare settings to address ongoing deficiencies in the quality and outcomes of care. The evidence for the effect of these policies has been inconclusive, especially in acute care. This systematic review focused on patient safety p4p in the hospital setting. Methods Five biomedical databases for quantitative studies were searched… Only five system-wide p4p policies have been implemented, and the quality of evidence was low overall. Just over half of the studies (52 %) included failed to observe improvement in outcomes, with positive findings heavily skewed towards poor quality evaluations. The exception was the Fragility Hip Fracture Best Practice Tariff (BPT) in England, where sustained improvement was observed across various evaluations… Findings underscore the importance of simple and transparent design, involvement of the clinical community, explicit links to other quality improvement initiatives, and gradual implementation of p4p initiatives.	Pay-for-performance and patient safety in acute care: A systematic review
Estimating the impact on patient safety of enabling the digital transfer of patients' prescription information in the English NHS	Camacho E. et al	Mar 2024	**Objectives** To estimate the no. and burden of medication errors associated with prescription information transfer within the National Health Service (NHS) in England and the impact of implementing an interoperable prescription information system (a single digital prescribing record shared across NHS settings) in reducing these errors. **Methods** … a probabilistic mathematical model … estimated the number of transition medication errors that would be undetected by standard medicines reconciliation… and scaled this up based on the annual no. of hospital admissions. … **Results** Annually, around 1.8 million… medication errors were estimated to occur at hospital transitions in England, affecting approx..380 000… patient	https://qualitysafety.bmj.com/content/early/2024/01/28/bmjqs-2023-016675

			episodes…. **Conclusions** An interoperable prescription information system could provide major benefits for patient safety. Likely additional benefits include… professional time saved, improved patient experience and care quality, quicker discharge and enhanced cross-organisational medicines optimisation…	
Health professionals' experiences of whistleblowing in maternal and newborn healthcare settings: A scoping review and thematic analysis	Cappet T. et al	May 2024	**Problem** Whistleblowing, which involves raising concerns about wrongdoing, carries risks yet can be crucial to ensuring the safety of health service users in maternal and newborn healthcare settings. Understanding of the experiences of health care professionals that enact whistleblowing in this context is currently limited. **Background** Notable inquiries involving maternity services…have shone an international spotlight on whistleblowing failures. **Aim** To identify and synthesise available literature addressing the experiences of healthcare professionals enacting whistleblowing in maternal and newborn care settings. **Methods …** Five academic databases were systematically searched for documents published between Jan 2013 and Oct 2023 with additional searches of Google Scholar and related reference lists. **Findings** Whilst 35 papers from international sources were identified, the majority originated from the UK… Thematic analysis identified three main themes: 'Structural Power', 'Perfectionism' and 'Bravery, Hope and Disappointment', each with sub-themes. **Discussion** Whistleblowing is frequently an altruistic act in a hierarchical system. It exposes poor practices and disrupts power dynamics, especially in challenging workplace cultures. Open disclosure, however, requires psychological safety**.** Obstacles persist, emphasising the need for a culture of trust and transparency led by individuals who embody the desired values. **Conclusion** Primary research on whistleblowing in maternal and newborn healthcare settings is limited. This study sheds light on power dynamics and factors that affect whistleblowing.	https://www.sciencedirect.com/science/article/pii/S1871519224000416
Establishment of a hospital group complaints staff network	Kenny O.	Apr 24	This article describes the rationale and development of a complaints staff network in a hospital group in Ireland… Staff who handle complaints.. have shown willingness to engage in the network and use it to access support. Membership of the network has more than doubled since its inception. This novel approach to sharing learning in complaints management at hospital-group level could be adopted in other healthcare organisations.	https://www.magonlinelibrary.com/doi/full/10.12968/bjhc.2023.0084
Quality of care transition, patient safety incidents, and patients' health status: a structural equation model on the complexity of the discharge process	Marsall M. et al	May 2024	**Background** The transition of patients between care contexts poses patient safety risks. Discharges to home from inpatient care can be associated with adverse patient outcomes… This study aimed to investigate the associations between the quality and safety of the discharge process, patient safety incidents, and health-related outcomes after discharge, considering the treatments' and patients' contextual factors in one comprehensive model. **Methods** Patients at least 18 years old and discharged home after at least three days of inpatient treatment received a self-report questionnaire. A total of N = 825 patients participated... **Results** Higher quality of care transition was related to a lower incidence of medication complications…and better health status but not with lower incidence of readmissions… **Conclusions** Quality and safety in the discharge process are critical to safe patient transitions to home care… high quality discharge processes are associated with a lower likelihood of patient safety incidents and better health status at home even, when sociodemographic and treatment-related characteristics are taken into account….	https://bmchealthservres.biomedcentral.com/articles/10.1186/s12913-024-11047-3

Impact of short-notice accreditation assessments on hospitals' patient safety and quality culture—A scoping review	Scanlan R. et al	Mar 2024	**Aim** To explore the published evidence describing the impact of short-notice accreditation assessments on hospitals' patient safety and quality (PS&Q) culture. **Methods** A scoping review was conducted to identify papers that provided an evaluation of short-notice accreditation processes…**Results** Totally, 3317 records were initially identified with 64 full-text studies screened by the reviewers. Five studies were deemed to meet …inclusion criteria, all studies reported variable evidence on the validity of health service or hosp accreditation processes and only three considered the concept of PS&Q culture in the context of accreditation. None of the five …report the impact of a short-notice accreditation process on a hospital's PS&Q culture. **Conclusions** Limited evidence exists to report on the effectiveness of hospital short-notice accreditation models. No study has been undertaken to understand the impact of short-notice accreditation on PS&Q cultures within hosp settings.	https://onlinelibrary.wiley.com/doi/10.1111/jan.16169

Section 2: Reports / Web pages

Reports / Web Pages	URL
Learning from patients: The impact of using patients' narratives on patient experience scores: Health Care Management Review	https://journals.lww.com/hcmrjournal/abstract/2024/01000/learning_from_patients__the_impact_of_using.2.aspx
Associations Between Organizational Communication and Patients' Experience of Prolonged Emotional Impact Following Medical Errors	https://pubmed.ncbi.nlm.nih.gov/38565471/

Section 3: Important Medicine Safety Information approved by the HPRA

A list of direct healthcare professional communications (DHPC) containing important new medicine safety information approved by the Health Products Regulatory Authority (HPRA) is contained in the table below. DHPCs are disseminated in Ireland to alert healthcare professionals of medicine safety issues for which there is a need to take immediate action or change current practice. The types of situations may include, for example, a new restriction of use or contraindication, new major warnings or precautions for use, new recommendations for preventing or treating adverse reactions. It is important that healthcare professionals are aware of DHPCs related to medicines they may prescribe or dispense.

Important Safety Information	Date of approval	URL
Pseudoephedrine: Risks of posterior reversible encephalopathy syndrome (PRES) and reversible cerebral vasoconstriction syndrome (RCVS)	09/02/2024	https://www.hpra.ie/docs/default-source/default-document-library/important-safety-information---pseudoephedrine897d152697826eee9b55ff00008c97d0.pdf?sfvrsn=0
Valproate - containing medicines: new measures regarding the potential risk of neurodevelopmental disorders in children of fathers treated with valproate in the 3 months prior to conception	19/02/2024	https://www.hpra.ie/docs/default-source/default-document-library/important-safety-information-valproate---containing-medicines.pdf?sfvrsn=0
PAXLOVID® ▼ (nirmatrelvir; ritonavir): reminder of life-threatening and fatal drug-drug interactions with certain immunosuppressants, including tacrolimus	20/03/2024	https://www.hpra.ie/docs/default-source/default-document-library/important-safety-information-paxlovid-(nirmatrelvir-ritonavir).pdf?sfvrsn=0

Connect with the Patient Safety Together Team

Website: www.hse.ie/pst/

Email: patientsafetytogether@hse.ie