Title: Hospital passports, patient safety and person centred care: a review of documents currently used for people with intellectual disabilities in the United Kingdom (Sept 2017)

Summary: Hospital passports have been introduced to address communication barriers that may limit access to appropriate healthcare for people with intellectual disabilities. Hospital passports are one way of enhancing safety and person-centred care, and need to be accessed and used as a basis for care planning. However, variation in format may limit this effectiveness and nurses should work with others to develop a more standardised approach which better meets the needs of all stakeholders.

Link to abstract (contact library for full article)


Title: Managing the costs of clinical negligence in trusts (Sept 2017)

Summary: This report calls on the government to take a stronger and more integrated approach in order to rein in the increasing cost of clinical negligence claims across the health and justice systems. It finds that over the last ten years, spending on the Clinical Negligence Scheme for Trusts has quadrupled from £0.4 billion in 2006-07 to £1.6 billion in 2016-17, while the number of successful clinical negligence claims where damages were awarded has more than doubled, from 2,800 to 7,300.

Link to full text

Source: National Audit Office

Title: Safe and effective staffing: nursing against the odds (Sept 2017)

Summary: RCN launched a survey of nursing and midwifery staff in the UK which asked people about their last shift or day worked in health or social care. The findings provide a strong voice from nursing staff, clearly describing the impact that poor staffing has on both patient care and their own wellbeing. Some of the experiences and stories shared via the survey have been included throughout the report.

Link to full text

Source: Royal College of Nursing

Title: Swarm: a quick and efficient response to patient safety incidents (Sept 2017)

Summary: Two years ago, a patient safety incident at North Bristol Trust led to the introduction of Swarm – a step change in how the trust responds to safety incidents. Swarm is a form of safety incident huddle that takes place as close as possible in time and place to the incident, allows blame-free investigation and leads to prompt action. This article describes how Swarm works, its advantages over root cause analysis, and how it is being embedded in the safety culture of North Bristol Trust.

(Contact library for full article)  
Source: Motuel, L. et al., Nursing Times, 113(9), pp. 36-38


Summary: Health systems are increasingly holding boards of healthcare organisations accountable for the quality of care they provide. Previous empirical research has found associations between certain board practices and higher quality patient care; however, little is known about how boards govern for QI.

Link to full text  
(NHS Athens account required or contact library)

Source: Jones, L. et al. (2017), BMJ Quality & Safety [Online First 8.7.17]
Title: Explaining and apologizing to patients after errors does not increase lawsuits, finds study (Oct 2017)

Summary: In the face of growing numbers of lawsuits, many US hospitals have introduced “communication and resolution” programs over the past few years. In these programs hospitals communicate with patients when adverse events have occurred, investigate and explain what happened, apologize where appropriate, and offer compensation where failure to follow standard procedures led to significant harm.


Title: Resilience and recovery: what the NHS can learn from the criminal justice and education sectors (Sept 2017)

Summary: Following Mid Staffs and other high-profile failures of NHS care, the Health Foundation commissioned research into what the NHS can learn from other sectors. A team from the University of Leicester and Cardiff University examined failure, recovery and resilience in the criminal justice system (policing, youth justice, prisons) and education.

Source: The Health Foundation

Title: Freedom to speak up guardian survey 2017: findings and recommendations (Sept 2017)

Summary: This report outlines the results of a survey of NHS whistleblowing guardians which aimed to understand how the role has been implemented, who is being appointed to the role and guardians' views on the Freedom to Speak Up initiative. The report makes ten recommendations for the development of the role as a result of the findings of the survey.

Source: CQC—National Guardian’s office

Title: Person centred care in 2017 (Sept 2017)

Summary: This report attempts to create a snapshot of the extent of person-centred care in the English health and care system, based on how people report their experience of treatment, care and support. This data was found through surveys of patients and service users. It concludes that NHS services do not give people adequate control of their own health and care, and there is no reporting of whether people’s care is coordinated across health and social care.

Source: National Voices

Title: Coming to a resolution: dealing with clinical negligence cases in the NHS (Sept 2017)

Summary: John Tingle, Associate Professor of Law, Nottingham Trent University, discusses the latest annual report from NHS Resolution, which provides useful information on recent clinical negligence cases.


Title: Professional regulation in health and social care (Oct 2017)

Summary: This House of Commons Library briefing describes the main functions of the UK’s health and social care professional regulators and outlines some of the prominent debates surrounding this area of policy and the case for reform.

Source: UK Parliament

Title: Safe handover (Oct 2017)

Summary: Miscommunication is one of the leading causes for adverse events resulting in death or serious injury to patients. The process of handovers can be improved, and the aim of this article is to provide practical guidance for clinicians on how to do this better.

Source: Merton, H. et al., BMJ Quality &Safety, 359:j4328